INTERMEDIATE CARE FACILITIES FOR MENTALLY RETARDED

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

This manual contains the policies and procedures governing care in intermediate care facilities for the mentally retarded (ICFs/MR), when provided under the Medicaid program. The Medicaid program is administered by the states under regulations established by the United States Department of Health and Human Services. Facilities may become certified as Medicaid providers by meeting program, administrative and facility conditions of participation.

The policies in this manual are from rules promulgated for Medicaid ICF/MR program by the Department of Human Services at 441 Iowa Administrative Code 82. These are based on Code of Federal Regulations sections entitled "Conditions of Participation for Intermediate Care Facilities for the Mentally Retarded," found at 42 CFR 483, Subpart I. The Department of Health and Human Services has provided **further** clarification through interpretive guidelines prepared to assist survey agencies, program participants, and certifying agencies to identify program intent. These guidelines are published as an addendum to the ICF/MR licensing rules at 481 CFR 64.

In this manual, Medicaid recipients who receive care in an ICF/MR are referred to as "residents." The Department of Human Services is referred to as "the Department."

CERTIFICATION PROCESS

A public or private facility wishing to obtain a provider agreement to serve Medicaid-eligible residents in an ICF/MR must proceed in the manner set forth below.

Certificate of Need

Service providers seeking Medicaid certification for ICF/MR conversion or construction shall address the following requirements of the Iowa Medicaid program before filing certificate of need applications.

1. **Inclusion in the community.** Written plans shall demonstrate individualized consumer access to and utilization of service and resources typically used by other residents of the area in which the proposed facility is to be located. The distance, availability of transportation, convenience of parking and physical accessibility to people with a range of disabilities shall be considered. The program name and home location must blend with characteristics of other homes in the area. There must be a broad range, number, and type of opportunities for social activities and interactions for individuals or groups small enough in size to be assimilated into the activity.

2. **Family-scale size.** Written plans shall demonstrate that the proposed facility will meet family-scale size conditions of two to eight persons per environment or be a size that would be common to the area or neighborhood in which the facility is proposed to be located.

3. **Location in community residential neighborhood.** If the proposed facility is located within a community residential neighborhood, written plans shall demonstrate the use of an existing structure or new construction which is consistent with the size and style of the neighborhood.

   The proposed facility shall not be located contiguous to another licensed health care facility or residential program for persons with disabilities. The number of residential programs for persons with disabilities in a community should be relative to community size, so that the number of programs is in keeping with the number, types, and range of services and supports in the community.

   If the proposed facility is located outside a community residential neighborhood, written plans shall demonstrate how these conditions shall be met and shall explain why a location outside a community residential neighborhood would be beneficial for the particular consumer population to be served.

Written plans shall be submitted to the Bureau of Long-Term Care, Department of Human Services, 1305 E Walnut Street, 5th Floor, Des Moines, Iowa 50319-0114, and to the Health Facilities Council, Iowa Department of Public Health, 321 E 12th Street, Des Moines, Iowa 50319. The Health Facilities Council shall consider the requirements set forth in this rule when reviewing certificate of need applications.

License

To participate in the Medicaid program, a facility shall be licensed as a hospital, nursing facility, or an intermediate care facility for the mentally retarded by the Department of Inspections and Appeals (DIA) under the Department of Inspections and Appeals rules 481 IAC Chapter 64.

A conditional license can be granted a new facility when there is a finding that in all probability the facility will be in full compliance upon commencement of operations.

The DIA shall grant the applicant a conditional license based upon information supplied by the applicant and the approved facility plans and construction.

Survey and Certification

The procedures to be followed in certifying a facility as meeting Medicaid requirements involve the facility, the Department of Inspections and Appeals (DIA) and the Department of Human Services. Before a provider agreement may be issued, the DIA must recommend certification as an ICF/MR, and the Department must certify the facility as a Medicaid vendor.

All survey procedures and the certification process shall be in accordance with the U.S. Department of Health and Human Services publication "Providers Certification State Operations Manual." The necessary steps leading to certification and issuance of a provider agreement for an existing facility are as follows:

1. The facility shall request an application form from the Department.

2. The Department shall transmit form 470-0254, *Institutional Medicaid Provider Application*, and a provider manual to the facility.

3. The facility shall complete its portion of the application form and submit it to the Department.

4. The Department shall review the application form and retain it until the DIA completes the Certification and Transmittal, HCFA 1539.

5. DIA schedules and completes a survey of the facility in conjunction with the Fire Marshal's office. At the time of initial survey for a new facility, the applicant must meet as many physical, administrative and service contract requirements as possible and should plan on meeting all other requirements for full compliance including those for staff, services, and operations for the residents at the scheduled resurvey.

   The initial survey of the facility shall be for the purpose of determining what recommended limited-term (less than 12 months) provider agreement should be entered into with the applicant. In the event the facility is to be recommended for limited or conditional certification, a resurvey shall occur no later than 30 days before the expiration of the facility's certification. At that time, survey for full compliance for recertification shall occur.

6. The DIA notifies the applicant of any deficiencies and asks for plan for correction of the deficiencies. In the event the facility is not to be recommended for limited or conditional certification, the DIA shall notify the applicant regarding reasons for its negative recommendations. The applicant shall then arrange for a resurvey by the DIA to occur when the objections which caused the negative recommendations to be made are removed.

7. The facility shall submit a plan of correction within 10 days after receipt of the written statement of deficiencies from the DIA Health Facilities Division. The DIA must approve this plan before the facility can be certified.

8. The DIA evaluates the survey findings and the full compliance plan of correction, and either recommends the facility for certification as an ICF/MR or recommends denial of certification. The date of certification will be the date of approval for the plan of correction.

If the DIA survey indicated deficiencies in the areas of American National Standards Institution, Life Safety Code, or environment and sanitation, a timetable detailing corrective measures shall be submitted to the DIA before a provider agreement can be issued. This timetable will not exceed two years from the date of initial certification and will detail corrective steps to be taken and when corrections will be accomplished. The following shall apply in these instances:

a. The DIA determines that the facility can make corrections within the two-year period.

b. During the period allowed for corrections, the facility shall be in compliance with existing state fire safety and sanitation codes and regulations.

c. The facility shall be surveyed at least semiannually until corrections are completed. The facility must have made substantial effort and progress in its plan of correction as evidenced by work orders, contracts, or other evidence.

9. When certification is recommended, the DIA notifies the Department recommending terms and conditions of a provider agreement.

10. The Department reviews the certification data and:

a. Transmits the provider agreement as recommended, or

b. Transmits the provider agreement for a term less than recommended by the DIA or elects not to execute an agreement.

Provider Agreements

An ICF /MR must be certified by the DIA for participation as an ICF /MR before a provider agreement may be issued. The effective date of a provider agreement may not be earlier than the date of certification.

For facilities without deficiencies, the provider agreement shall be issued for a period not to exceed 12 months. The agreement shall be for the term of and in accordance with the provisions of certification, except that for good cause, the Department may elect to execute an agreement for a term less than the period of certification, elect not to execute an agreement, or cancel an agreement.

For facilities with deficiencies, a new provider agreement may be executed for a period not to exceed 60 days from the time required to correct deficiencies, up to a period of 12 months. Or a new provider agreement may be issued for a period of up to 12 months, subject to automatic cancellation 60

days following the scheduled date for correction, unless required corrections have been completed, or unless the survey agency finds and notifies the Department that the facility has made substantial progress in correcting the deficiencies and has resubmitted in writing a new plan of correction acceptable to the survey agency.

There will be no new agreement if the facility continues to be out of compliance with the same standards at the end of the term of agreement.

The Department may, for good cause, elect not to execute an agreement. Good cause is defined as a continued or repeated failure to operate an ICF/MR in compliance with Medicaid rules.

The Department may at its option extend an agreement with a facility for two months under either of the following conditions:

1. The health and safety of the residents will not be jeopardized thereby, and, the extension is necessary to prevent irreparable harm to the facility or hardship to the resident.

2. It is impracticable to determine whether the facility is complying with the provisions and requirements of the provider agreement.

When it becomes necessary to cancel or refuse to renew a Medicaid provider agreement, federal financial participation may continue for 30 days beyond the date of cancellation, if the extension is necessary to ensure the orderly transfer of residents. See also Appeals of Decertification.

PHYSICAL ENVIRONMENT

The facility shall provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately equipped and sound-treated areas for hearing and other evaluations if they are conducted in the facility) to enable staff to provide residents with needed services as required by this manual and as identified in each resident's individual program plan.

Bedrooms

Bedrooms shall be rooms that have at least one outside wall. Each bedroom shall have direct outside ventilation by means of windows, air conditioning, or mechanical ventilation. If a bedroom is below grade level, it shall have a window that is usable as a second means of escape by the resident. The window shall be no more than 44 inches measured to the window sill above the floor. If the facility is surveyed under the Health Care Occupancy Chapter of the Life Safety Code, the window must be no more than 36 inches measured to the window sill above the floor.

Bedrooms shall accommodate no more than four residents, unless granted a variance. DIA may grant a variance from the limit of four residents per room only if a physician who is a member of the interdisciplinary team and who is a qualified mental retardation professional certifies that each resident to be placed in a bedroom housing more than four persons is so severely medically impaired as to require direct and continuous monitoring during sleeping hours and documents the reasons why housing in a room of four or fewer persons would not be medically feasible.

Bedrooms shall be equipped with or located near toilet and bathing facilities. Multiple-resident bedrooms must measure at least 60 square feet per resident. Single rooms must measure at least 80 square feet. In all facilities initially certified or in buildings constructed or with major renovations or conversions, bedrooms shall have walls that extend from floor to ceiling.

The facility shall provide each resident with:

1. A separate bed of proper size and height for the convenience of the resident.

2. A clean, comfortable mattress and bedding appropriate to the weather and climate.

3. Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.

4. Suitable storage space, accessible to residents, for personal possessions such as televisions, radios, prosthetic equipment and clothing.

5. Adequate clean linen and dirty linen storage areas.

The facility shall provide space and equipment for daily out-of-bed activity for all residents who are not yet mobile, except those who have a short-term illness or those few residents for whom out-of-bed activity is a threat to health and safety.

Resident Bathrooms

The facility shall provide toilet and bathing facilities appropriate in number, size, and design to meet the needs of the residents. The facility shall provide for individual privacy in toilets, bathtubs, and showers.

Safety

The facility shall be in compliance with all applicable provisions of federal, state and local laws, regulations, and codes pertaining to health, safety, and sanitation.

The facility shall maintain the temperature and humidity within a normal comfort range by heating, air conditioning, or other means and ensure that the heating apparatus does not constitute a burn or smoke hazard to residents.

In areas of the facility where residents who have not been trained to regulate water temperature are exposed to hot water, the facility shall ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.

The facility shall provide a sanitary environment to avoid sources and transmission of infections. There shall be an active program for the prevention, control, and investigation of infection and communicable diseases. The facility shall implement successful corrective action in affected problem areas. The facility shall maintain a record of incidents and corrective actions related to infections. The facility shall prohibit employees with symptoms or signs of a communicable disease from direct contact with residents and their food.

The facility shall have floors that have a resilient, nonabrasive, and slip-resistant surface. If the area used by residents is carpeted and serves residents who lie on the floor or ambulate with parts of their bodies, other than feet, touching the floor, the carpeting shall be nonabrasive. Exposed floor surfaces and floor coverings shall promote mobility in areas used by residents and promote maintenance of sanitary conditions.

The facility shall remove or cover interior paint or plaster containing lead so that it is not accessible to residents. Lead-free paint shall be used inside the facility.

Except as specified in this Handbook, the facility shall meet the applicable provisions of either the Health Care Occupancies Chapters or the Residential Board and Care Occupancies Chapter of the Life Safety Code (LSC) of the National Fire Protection Association, 1985 edition, which is incorporated by reference. DIA may apply a single chapter of the LSC to the entire facility or may apply different chapters to different buildings or parts of buildings, as permitted by the LSC.

A facility that meets the LSC definition of a residential board and care occupancy and that has 16 or fewer beds shall have its evacuation capability evaluated in accordance with the Evacuation Difficulty Index of the LSC (Appendix F).

For facilities that meet the LSC definition of a health care occupancy, the Health Care Financing Administration may waive specific provisions of the LSC for a period it considers appropriate, if the waiver would not adversely affect the health and safety of the residents and rigid application of specific provisions would result in an unreasonable hardship for the facility.

DIA may apply the state's fire and safety code instead of the LSC if the Secretary of the Department of Health and Human Services finds that the state has a code imposed by state law that adequately protects a facility's residents.

Compliance on November 28, 1982, with the 1967 edition of the LSC or compliance on April 18, 1986, with the 1981 edition of the LSC, with or without waivers, is considered to be compliance with this standard, as long as the facility continues to remain in compliance with that edition of the code.

For facilities that meet the LSC definition of a residential board and care occupancy and that have more than 16 beds, the DIA may apply the state's fire and safety code as specified above.

Disaster Plans and Drills

The facility shall develop and implement detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents. The facility shall communicate, periodically review, make the plan available, and provide training to the staff.

The facility shall hold evacuation drills at least quarterly for each shift of personnel and under varied conditions. Drills shall ensure that all personnel on all shifts, including live-in and relief staff, are trained to perform assigned tasks, and are familiar with the use of the facility's fire protection features. The facility shall actually evacuate residents during at least one drill each year on each shift and make special provisions for the evacuation of residents with physical disabilities. During fire drills, residents may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.

The facility shall file a report and evaluation on each evacuation drill; evaluate the effectiveness of emergency and disaster plans and procedures; investigate all problems with evacuation drills, including accidents; and take corrective action.

ADMINISTRATION

Disclosure of Ownership

The facility shall supply to the licensing agency full and complete information, and promptly report any changes which would affect the current accuracy of the information, as to identify:

1. Each person having a direct or indirect ownership interest of five percent or more in the facility and the owner in whole or in part of any property or assets (stock, mortgage, deed of trust, note, or other obligation) secured in whole or in part by the facility.

2. Each officer and director of the corporation, if the facility is organized as a corporation.

3. Each partner, if the facility is organized as a partnership.

Governing Body

The facility shall identify an individual or individuals to constitute the governing body of the facility. The governing body shall:

- Exercise general policy, budget, and operating direction over the facility;
- Set the qualifications for the administrator of the facility (in addition to those already set by state law); and
- Appoint the administrator.

Services Provided Under Agreements With Outside Sources

If a service required under this manual is not provided directly, the facility shall have a written agreement with an outside program, resource, or service to furnish the necessary service, including emergency and other health care. The agreement shall:

- Contain the responsibilities, functions, objectives, and other terms agreed to by both parties.
- Provide that the facility is responsible for ensuring that the outside services meet the standards for quality of services contained in this manual. If living quarters are not provided in a facility owned by the ICF/MR, the ICF/MR remains directly responsible for the standards relating to physical environment.

The facility shall ensure that outside services meet the needs of each resident.

Records

The facility shall, as a minimum, maintain the following records:

- All records required by the Department of Public Health and Department of Inspections and Appeals.
- Residents' medical records.
- Records of all treatments, drugs, and services for which vendor payments have been made, or are to be made under the Medicaid program, including the authority for and the date of administration of the treatment, drugs, or services.

- Documentation in each resident's record which enables the Department to verify that each charge is due and proper before payment.
- Financial records maintained in the standard, specified form including the facility's most recent audited cost report, form 470-0377, *Financial and Statistical Report*.
- Census records, to include the date, number of residents at the beginning of each day, names of residents admitted, and names of residents discharged.
- Resident accounts.
- In-service education records.
- Inspection reports pertaining to conformity with federal, state, and local laws.
- Disaster-preparedness reports.
- All other records as may be found necessary by the Department in determining compliance with any state or federal regulations.

Records shall be retained in the facility for a minimum of five years or until an audit is performed on those records, whichever is longer. All records shall be retained within the facility upon change of ownership.

Resident Records

The facility must:

- Develop and maintain a record keeping system that:
  - Includes a separate record for each resident, and
  - Documents the resident's health care, active treatment, social information and protection of the resident's rights.
- Provide each identified residential living unit with appropriate aspects of each resident's record.
- Keep confidential all information contained in the resident's records, regardless of the form or storage method of the records.
- Develop and implement policies and procedures governing the release of any resident information, including consents necessary from the resident or parents (if the resident is a minor) or legal guardian.

Any person who makes an entry in a resident's record must make it legibly, date it, and sign it. The facility must provide a legend to explain any symbol or abbreviation used in a resident's record.

Personal Needs Accounts

When the facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident's personal needs funds. This accounting system is subject to audit by state representatives and must meet the following criteria.

Upon a resident's admission to the facility, a ledger sheet shall be credited with the resident's total incidental money on hand. Thereafter, the ledger must be kept current on a monthly basis. The facility may combine this accounting with the disbursement section showing the date, amount given the resident, and the resident's signature. A separate ledger sheet must be maintained for each resident.

When something is purchased for the resident and is not a direct cash disbursement to the resident, the expenditure item in the ledger must be supported by a dated receipt signed by the resident or the resident's legal representative. The receipt must indicate the article furnished for the resident's benefit.

Personal funds must not be turned over to persons other than the resident's legal representative or other persons selected by the resident. With the consent of the resident (if the resident is able and willing to give consent), the administrator may turn over personal funds belonging to the resident to a close relative or friend to purchase a particular item. However, an itemized dated receipt signed by the resident or the representative shall be deposited in the resident's file.

The receipts for each resident must be kept until cancelled by auditors. The ledger and receipts for each resident shall be made available for periodic audits by an accredited DIA representative. The representative shall make an audit certification at the bottom of the ledger sheet. Support receipts may then be destroyed.

Upon a resident's death, a receipt must be obtained from the next of kin or the resident's guardian before releasing the balance of personal needs funds. When the resident has been receiving a grant from the Department for all or part of the personal needs, any funds shall revert to the Department. The Department shall turn the funds over to the resident's estate.

STAFF

Qualified Mental Retardation Professional

Each resident's active treatment program shall be integrated, coordinated, and monitored by a qualified mental retardation professional who has at least one year of experience working directly with persons with mental retardation or other developmental disabilities and is one of the following:

1. A doctor of medicine or osteopathy.
2. A registered nurse.
3. A person who holds at least a bachelor's degree in a professional category specified below.

Professional Program Staff

Each resident shall receive the professional program services needed to implement the active treatment program defined by each resident's individual program plan. The facility shall have available enough qualified professional staff to carry out and monitor the various professional interventions in accordance with the stated goals and objectives of every individual program plan.

Professional program staff shall be licensed, certified, or registered, as applicable to provide professional services by the state in which the staff practices. Those professional program staff who do not fall under the jurisdiction of state licensure, certification, or registration requirements shall meet the following qualifications:

1. To be designated as an occupational therapist, a person shall be eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.

2. To be designated as an occupational therapy assistant, a person shall be eligible for certification as an occupational therapy assistant by the American Occupational Therapy Association or another comparable body.

3. To be designated as a physical therapist, a person shall be eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.

4. To be designated as a physical therapy assistant, a person shall be eligible for registration as a physical therapy assistant by the American Physical Therapy Association or be a graduate of a two-year college-level program approved by the American Physical Therapy Association or another comparable body.

5. To be designated as a psychologist, a person shall have at least a master's degree in psychology from an accredited school.

6. To be designated as a social worker, a person shall hold a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body or hold a bachelor of social work degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body.

7. To be designated as a speech-language pathologist or audiologist, a person shall be eligible for a Certificate of Clinical Competence in Speech-Language Pathology or Audiology granted by the American Speech-Language Hearing Association or another comparable body or meet the educational requirements for certification and be in the process of accumulating the supervised experience required for certification.

8. To be designated as a professional recreation staff member, a person shall have a bachelor's degree in recreation or in a specialty area such as art, dance, music, or physical education.

9. To be designated as a professional dietitian, a person shall be eligible for registration by the American Dietetics Association.

10. To be designated as a human services professional, a person shall have at least a bachelor's degree in a human services field (including, but not limited to, sociology, special education, rehabilitation counseling, and psychology).

If the resident's individual program plan is being successfully implemented by the facility staff, professional program staff meeting these qualifications are not required except, for qualified mental retardation professionals, who must meet the requirements set forth here or be a doctor or nurse.

Professional program staff shall participate as members of the interdisciplinary team in relevant aspects of the active treatment process. Professional program staff shall work directly with residents and with paraprofessional, nonprofessional, and other professional program staff who work with residents. Professional program staff shall participate in ongoing staff development and training in both formal and informal settings with other professional, paraprofessional, and nonprofessional staff members.

Nursing Staff

The facility shall employ or arrange for licensed nursing services sufficient to care for residents' health needs including those residents with medical care plans. Nurses providing services in the facility shall have a current license to practice in the state.

The facility shall use registered nurses as appropriate and required by state law to perform the health services specified in this manual. If the facility uses only licensed practical or vocational nurses to provide health services, it shall have a formal arrangement with a registered nurse to be available for verbal or on-site consultation with the licensed practical or vocational nurse. Nonlicensed nursing personnel who work with residents under a medical care plan shall do so under the supervision of licensed persons.

Direct Care Staff

The facility shall provide sufficient direct care staff to manage and super vise residents in accordance with their individual program plans. The facility shall not depend upon residents or volunteers to perform direct care services for the facility.

Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. There shall be responsible direct care staff on duty and awake on a 24-hour basis when residents are present to take prompt, appropriate action in cases of injury, illness, fire or other emergency, in each defined residential living unit housing: (a) residents for whom a physician has ordered a medical care plan; (b) residents who are aggressive, assaultive or security risks; (c) more than 16 residents; or (d) fewer than 16 residents within a multi-unit building.

There shall be a responsible direct care staff person on duty on a 24-hour basis when residents are present to respond to injuries and symptoms of illness and to handle emergencies in each defined residential living unit housing: (a) residents for whom a physician has not ordered a medical care plan; (b) residents who are not aggressive, assaultive or security risks; and (c) 16 or fewer residents.

Direct care staff shall be provided by the facility in the following minimum ratios of direct care staff to residents:

1. For each defined residential living unit serving children under the age of 12, severely and profoundly retarded residents, residents with severe physical disabilities, or residents who are aggressive, assaultive, or security risks or who manifest severely hyperactive or psychotic-like behavior, the staff-to-resident ratio is 1 to 3.2.

2. For each defined residential living unit serving moderately retarded residents, the staff-to-resident ratio is 1 to 4.

3. For each defined residential living unit serving residents who function within the range of mild retardation, the staff-to-resident ratio is 1 to 6.4.

4. When there are no residents present in the living unit, a responsible staff member must be available by telephone.

Provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct resident care duties

Staff Training Program

Provide each employee with initial and continuing training that enables the employee to perform the employee's duties effectively, efficiently, and competently. For employees who work with residents, focus training on skills and competencies directed toward residents' developmental, behavioral, and health needs.

Staff shall be able to demonstrate the skills and techniques necessary to:

- Administer interventions to manage the inappropriate behavior of residents.
- Implement the individual program plans for each resident for whom they are responsible.

RESIDENT ADMISSIONS

Before placement in an ICF/MR, all eligible persons shall be referred through an approved case management program and through a Central Point of Coordination process to IFMC.

The case management program shall identify any appropriate alternatives to the placement and shall inform the consumer or the consumer's representative of the alternatives. Once informed, the consumer or legal representative is free to select any option for which the consumer qualifies, including ICF/MR care.

Upon receipt of an initial ICF/MR request, the Central Point of Coordination (CPC) shall take one of the following actions:

- Refer the ICF/MR request to IFMC for level of care determination,
- Offer a home- or community-based alternative, or
- Refer the person back to the case management program for further consideration of service needs.

The CPC's action must take place within 30 days of receipt of a referral.

Persons seeking Medicaid payment for ICF/MR placement must be referred to IFMC by the CPC with responsibility for the person. If IFMC approves ICF/MR level of care, the eligible person, or the person's representative, is free to seek placement in the facility of the person's or the person's representative's choice.

Persons who are admitted by the facility shall be in need of and receiving active treatment services. Admission decisions shall be based on a preliminary evaluation of the person that is conducted or updated by the facility or by outside sources.

The preliminary evaluation shall contain background information as well as currently valid assessments of functional developmental, behavioral, social, health, and nutritional status. The evaluation shall determine if the facility can provide for the person's needs and if the person is likely to benefit from placement in the facility.

Do not house residents of grossly different ages, developmental levels, and social needs in close physical or social proximity, unless the housing is planned to promote the growth and development of all those housed together.

Do not segregate residents solely on the basis of their physical disabilities. Integrate residents who have ambulation deficits or who are deaf, blind, or have seizure disorders with others of comparable social and intellectual development.

It is important that people being placed feel that their needs and perceptions have been understood, and that placement is designed to achieve positive goals. The following procedures are recommended to enhance the comfort and early adjustment of a person to this new living arrangement:

- Orient the resident to the physical plant and the facility staff.
- Introduce the resident to other residents and encourage the resident to become well acquainted early with those in the immediate living area.
- Discuss the resident's medical records and care plan with the resident.
- Encourage the resident to continue with interests and social responsibilities and contacts as early as possible after admission.
- Discuss the resident's placement, feelings about the placement, and progress, goals, and plans with the resident periodically.
- Give the resident the opportunity to discuss with the administrator and other staff members the resident's condition and the reasons for coming to the facility.
- Encourage the resident to express feelings about admission and to ask questions to alleviate any concerns and anxieties.

PROVISION OF SERVICES

Each resident shall receive a continuous active treatment program. "Active treatment" means aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this manual. Active treatment shall be directed toward:

- The acquisition of the behaviors necessary for the resident to function with as much self-determination and independence as possible.
- The prevention or deceleration of regression or loss of current optimal functional status.

"Active treatment" does not include services to maintain generally independent residents who are able to function with little supervision or in the absence of a continuous active treatment program.

Appropriate facility staff shall participate in interdisciplinary team meetings. Participation by other agencies serving the resident is encouraged. Participation by the resident, the resident's parents (if the resident is a minor), or the resident's legal guardian is required unless that participation is unobtainable or inappropriate.

Resident Assessment

Within 30 days after admission, the interdisciplinary team shall perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted before admission. The comprehensive functional assessment shall take into consideration the resident's age (for example, child, young adult, elderly person) and the implications for active treatment at each stage, as applicable. The assessment shall identify:

1. The presenting problems and disabilities and, where possible, their causes.

2. The resident's specific developmental strengths.

3. The resident's specific developmental and behavioral management needs.

4. The resident's need for services, without regard to the actual availability of the services needed.

5. Physical development and health, nutritional status, sensorimotor development, affective development, speech and language development and auditory functioning, cognitive development, social development, adaptive behaviors, or independent living skills necessary for the resident to be able to function in the community, and vocational skills, as applicable.

Individual Program Plan

Each resident shall have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to identifying the resident's needs, as described by the comprehensive functional assessments required below, and to designing programs that meet the resident's needs.

Within 30 days after admission, the interdisciplinary team shall prepare for each resident an individual program plan.

The individual program plan shall describe relevant interventions to support the resident toward independence. Plans shall include, for those residents who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the resident is developmentally incapable of acquiring them.

The plan shall identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. The plan shall specify the reason for each support, the situations in which each is to be applied, and a schedule for the use of each support. Plans shall provide the residents who have multiple disabling conditions spend a major portion of each waking day out of bed and outside the bedroom area, moving about by various methods and devices whenever possible.

Plans shall include opportunities for resident choice and self-management.

The plan shall state the specific objectives necessary to meet the resident's needs, as identified by the comprehensive assessment and the planned sequence for dealing with those objectives. These objectives shall be stated separately, in terms of a single behavioral outcome. They shall be assigned projected completion dates and be expressed in behavioral terms that provide measurable indices of performance. Objectives shall be organized to reflect a developmental progression appropriate to the individual and be assigned priorities.

Each written training program designed to implement the objectives in the individual program plan shall specify:

1. The person responsible for the program.

2. The methods to be used and the schedule for use of the method.

3. The type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives.

4. The inappropriate resident behaviors, if applicable.

5. Provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.

A copy of each resident's individual program plan shall be made available to all relevant staff, including staff of other agencies who work with the resident, and to the resident, parents (if the resident is a minor) or legal guardian. The plan shall identify the location where program strategy information (which shall be accessible to any person responsible for implementation) can be found.

Program Implementation

As soon as the interdisciplinary team has formulated a resident's individual program plan, each resident shall receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

The facility shall develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Except for those facets of the individual program plan that must be implemented only by licensed personnel, each resident's individual program plan shall be implemented by all staff who work with the resident, including professional, paraprofessional and nonprofessional staff.

Data relative to accomplishment of the criteria specified in individual program plan objectives shall be documented in measurable terms. The facility shall document significant events that are related to the resident's individual program plan and assessments and that contribute to an overall understanding of the resident's ongoing level and quality of functioning.

Program Monitoring and Change

The individual program plan shall be reviewed at least by the qualified mental retardation professional and revised as necessary. This includes, but is not limited to, situations in which the resident:

a. Has successfully completed an objective or objectives identified in the individual program plan.

b. Is regressing or losing skills already gained.

c. Is failing to progress toward identified objectives after reasonable efforts have been made.

d. Is being considered for training toward new objectives.

At least annually, the interdisciplinary team shall review the comprehensive functional assessment of each resident for relevancy and update it as needed. The individual program plan shall be revised, as appropriate.

Staff Conduct Toward Residents

The facility shall develop and implement written policies and procedures for the management of conduct between staff and residents. These policies and procedures shall:

1. Promote the growth, development, and independence of the resident.

2. Address the extent to which resident choice will be accommodated in daily decision-making, emphasizing self-determination and self-management, to the extent possible.

3. Specify resident conduct to be allowed or not allowed.

4. Be available to all staff, residents, parents of minor children, and legal guardians.

To the extent possible, residents shall participate in the formulation of these policies and procedures.

Residents shall not discipline other residents, except as part of an organized system of self-government, as set forth in facility policy.

Management of Inappropriate Resident Behavior

The facility shall develop and implement written policies and procedures that govern the management of inappropriate resident behavior, consistent with the provisions staff conduct toward residents. These procedures shall specify all facility-approved interventions to manage inappropriate resident behavior.

Procedures shall address the use of time-out rooms, the use of physical restraints, the use of drugs to manage inappropriate behavior, the application of painful or noxious stimuli, the staff members who may authorize the use of specified interventions, and a mechanism for monitoring and controlling the use of these interventions.

The procedures shall designate these interventions on a hierarchy to be implemented ranging from most positive or least intrusive to least positive or most intrusive.

Before using more restrictive techniques, the facility shall ensure that the resident's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and have been demonstrated to be ineffective.

Interventions to manage inappropriate resident behavior shall be employed with sufficient safeguards and supervision to ensure that the safety, welfare, and civil and human rights of residents are adequately protected. Techniques to manage inappropriate behavior shall never be used for disciplinary purposes, for the convenience of staff, or as a substitute for an active treatment program.

The use of systematic interventions to manage inappropriate resident behavior shall be incorporated into the resident's individual program plan. Standing or as-needed programs to control inappropriate behavior are not permitted.

Oversight Committee

The facility shall designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, residents (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate resident behavior, and persons with no ownership or controlling interest in the facility to:

a. Review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to resident protection and rights.

b. Ensure that these programs are conducted only with the written informed consent of the resident, parent (if the resident is a minor), or legal guardian.

c. Review, monitor, and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of resident rights and funds, and any other area that the committee believes needs to be addressed.

These provisions for committee review may be modified only if, in the judgement of the Department of Inspections and Appeals, court decrees, state law, or regulations provide for equivalent resident protection and consultation.

Time-Out Rooms

A resident may be placed in a room from which egress is prevented only if the following conditions are met:

a. The placement is a part of an approved systematic time-out program.

b. The resident is under the direct constant visual supervision of designated staff.

c. The door to the room is held shut by staff or by a mechanism requiring constant physical pressure from a staff member to keep the mechanism engaged.

Placement of a resident in a time-out room shall not exceed one hour. Residents placed in time-out rooms shall be protected from hazardous conditions including, but not limited to, presence of sharp corners and objects, uncovered light fixtures, unprotected electrical outlets. The facility shall keep a record of time-out activities.

Physical Restraints

The facility may employ physical restraint only:

a. As an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied.

b. As an emergency measure, but only if absolutely necessary to protect the resident or others from injury.

c. As a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for resident protection during the time that a medical condition exists.

Authorization to use or extend restraints as an emergency shall be in effect no longer than 12 consecutive hours and shall be obtained as soon as the resident is restrained or stable. The facility shall not issue orders for restraint on a standing or as needed basis.

A resident placed in restraint shall be checked at least every 30 minutes by staff trained in the use of restraints and shall be released from the restraint as quickly as possible. A record of these checks and usage shall be kept.

Restraints shall be designated and used so as not to cause physical injury to the resident and so as to cause the least possible discomfort. Barred enclosures shall not be more than three feet in height and shall not have tops. Opportunity for motion and exercise shall be provided for a period of not less than 10 minutes during each two-hour period in which restraint is employed. A record of the activity shall be kept.

Drug Usage

Drugs used for control of inappropriate behavior shall be approved by the interdisciplinary team. Drugs shall be used only as an integral part of the resident's individual program plan that is directed specifically towards the reduction and eventual elimination of the behaviors for which the drugs are employed. Drugs used for control of inappropriate behavior shall not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs.

The facility shall not use drugs in doses that interfere with the individual resident's daily living activities. Drugs used for control of inappropriate behavior shall be monitored closely, in conjunction with the physician and the drug regimen review requirements, for desired responses and adverse consequences by facility staff. These drugs shall be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated.

Health Care Services

The facility shall furnish, maintain in good repair, and teach residents to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the residents.

Physician Services

The facility shall provide or obtain preventive and general medical care for each resident. The facility shall ensure the availability of physician services 24 hours a day. To the extent permitted by state law, the facility may utilize physician assistants and nurse practitioners to provide physician services as described in this manual.

A physician shall participate in the establishment of each newly admitted resident's initial individual program plan.

The physician shall develop, in coordination with licensed nursing personnel, a medical care plan of treatment for a resident if the physician determines that an individual resident requires 24-hour licensed nursing care. This plan shall be integrated in the individual program plan.

The facility shall provide or obtain annual physical examinations of each resident that include, at a minimum, the following:

a. Evaluation of vision and hearing.

b. Immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on the Control of Infectious Diseases of the American Academy of Pediatrics.

c. Routine screening laboratory examinations as determined necessary by the physician, and special studies when needed.

d. Tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section of diseases of the chest of the American academy of Pediatrics, or both.

Nursing Services

The facility shall provide residents with nursing services in accordance with their needs. These services shall include:

a. Participation as appropriate in the development, review, and update of an individual program plan as part of the interdisciplinary team process.

b. The development, with a physician, of a medical care plan of treatment for a resident when the physician has determined that an individual resident requires such a plan.

c. For those residents certified as not needing a medical care plan, a review of their health status. This review shall be by a direct physical examination by a licensed nurse.

   Reviews shall be done quarterly or more frequently, depending on resident need, and be recorded in the client's record.

   Reviewers shall result in any necessary action including referral to a physician to address resident health problems.

d. Other nursing care as prescribed by the physician or as identified by resident needs.

e. Implementing, with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to:

   (1) Training residents and staff as needed in appropriate health and hygiene methods.

   (2) Control of communicable diseases and infections, including the instruction of other personnel in methods of infection control.

   (3) Training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the residents.

Dental Services

The facility shall provide or make arrangements for comprehensive diagnostic and treatment services for each resident from qualified personnel, including licensed dentists and dental hygienists, either through organized dental services in-house or through arrangement.

A complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's oral condition, shall be performed not later than one month after admission to the facility, unless the examination was completed within 12 months before admission. Periodic examination and diagnosis shall be performed at least annually, including radiographs when indicated and detection of manifestations of systemic disease. A review of the results of examination and entry of the results shall be entered in the client's dental record.

If appropriate, dental professionals shall participate in the development, review, and update of an individual program plan as part of the interdisciplinary process either in person or through written report to the interdisciplinary team.

The facility shall provide education and training in the maintenance of oral health.

The facility shall ensure comprehensive dental treatment services that include the availability for emergency dental treatment on a 24-hour-a-day basis by a licensed dentist. Dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health shall be available to resident.

If the facility maintains an in-house dental service, the facility shall keep a permanent dental record for each resident, with a dental summary maintained in the resident's living unit. If the facility does not maintain an in-house dental service, the facility shall obtain a dental summary of the results of dental visits and maintain the summary in the resident's living unit.

Pharmacy Services

The facility shall provide or make arrangements for the provision of routine and emergency drugs and biologicals to its residents. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy.

A pharmacist with input from the interdisciplinary team shall review the drug regimen of each resident at least quarterly. The pharmacist shall report any irregularities in residents' drug regimens to the prescribing physician and interdisciplinary team. The pharmacist shall prepare a record of each resident's drug regimen reviews and the facility shall maintain that record.

As appropriate, the pharmacist shall participate in the development, implementation, and review of each resident's individual program plan, either in person or through written report to the interdisciplinary team.

The facility shall have an organized system for drug administration that identifies each drug up to the point of administration. An individual medication administration record shall be maintained for each resident. The system shall ensure that:

a. All drugs are administered in compliance with the physician's orders.

b. All drugs, including those that are self-administered, are administered without error.

c. Unlicensed personnel are allowed to administer drugs only if state law permits.

d. Residents are taught how to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.

e. The resident's physician is informed of the interdisciplinary team's decision that self-administration of medications is an object for the client.

f. No resident self-administers medications until the resident demonstrates the competency to do so.

g. Drugs used by residents while not under the direct care of the facility are packaged and labeled in accordance with state law

h. Drug administration errors and adverse drug reactions are recorded and reported immediately to a physician.

The facility shall store drugs under proper conditions of sanitation, temperature, light, humidity, and security. The facility shall keep all drugs and biologicals locked, except when being prepared for administration. Only authorized persons may have access to the keys to the drug storage area. Residents who have been trained to self-administer drugs may have access to keys to their individual drug supply.

The facility shall maintain records of the receipt and disposition of all controlled drugs. The facility shall, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in schedules II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 et seq.). If the facility maintains a licensed pharmacy, the facility shall comply with the regulations for controlled drugs.

Labeling of drugs and biologicals shall be based on currently accepted professional principles and practices, and shall include the appropriate accessory and cautionary instructions, as well as the expiration date, if applicable. The facility shall remove from use outdated drugs and drug containers with worn, illegible, or missing labels.

Drugs and biologicals packaged in containers designated for a particular resident shall be immediately removed from the resident's current medication supply if discontinued by the physician.

Laboratory Services

Laboratory means an entity for the microbiological, serological, chemical, hematological, radio-bioassay, cytological, immunohematological, pathological, or other examination of materials derived from the human body, for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or assessment of a medical condition.

If a facility chooses to provide laboratory services, the laboratory shall meet the management requirements specified in 42 CFR 493.1407 and provide personnel to direct and conduct the laboratory services.

The laboratory director shall be technically qualified to supervise the laboratory personnel and test performance and shall meet licensing or other qualification standards established by the state with respect to directors of clinical laboratories.

The laboratory director shall provide adequate technical supervision of the laboratory services and ensure that tests, examinations and procedures are properly performed, recorded, and reported.

The laboratory director shall ensure that the staff has appropriate education, experience, and training to perform and report laboratory tests promptly and proficiently; is sufficient in number for the scope and complexity of the services provided; and receives in-service training appropriate to the type of complexity of the laboratory services offered.

The laboratory technologists shall be technically competent to perform test procedures and report test results promptly and proficiently.

The laboratory shall meet the proficiency testing requirements specified in 42 CFR 493.801. The laboratory shall meet the quality control requirements specified in 42 CFR 493.1501. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory shall be an approved Medicare laboratory.

Dietetic Services

Each resident shall receive a nourishing, well-balanced diet, including modified and specially prescribed diets. The resident's interdisciplinary team, including a qualified dietitian and physician, shall prescribe all modified and special diets, including those used as a part of a program to manage inappropriate resident behavior.

A qualified dietitian shall be employed either full time, part time, or on a consultant basis, at the facility's discretion. If a qualified dietitian is not employed fulltime, the facility shall designate a person to serve as the director of food services.

Unless otherwise specified by medical needs, the diet shall be prepared at least in accordance with the latest edition of the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, adjusted for age, sex, disability, and activity. Foods proposed for use as a primary reinforcement of adaptive behavior shall be evaluated in light of the resident's nutritional status and needs.

Each resident shall receive at least three meals daily, at regular times comparable to normal mealtimes in the community. Not more than 14 hours shall elapse between a substantial evening meal and breakfast of the following day. On weekends and holidays when a nourishing snack is provided at bedtime, 16 hours may elapse between a substantial evening meal and breakfast. Not less than 10 hours shall elapse between breakfast and the evening meal of the same day, except as provided above.

Menus shall be prepared in advance and shall provide a variety of foods at each meal.

Menus shall be different for the same days of each week and adjusted for seasonal change. Menus shall include the average portion sizes for menu items. Menus for food actually served shall be kept on file for 30 days.

Food shall be served in appropriate quantity, at appropriate temperature, and in a form consistent with the developmental level of the resident.

The facility shall serve meals for all residents, including persons with ambulation deficits, in dining areas, unless otherwise specified by the interdisciplinary team or a physician. The facility shall provide table service for all residents who can and will eat at a table, including residents in wheelchairs. The facility shall equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each resident.

The facility shall supervise and staff dining rooms adequately to direct self-help dining procedure, to ensure that each resident receives enough food, and to ensure that each resident eats in a manner consistent with the resident's developmental level. Staff shall ensure that each resident eats in an upright position, unless otherwise specified by the interdisciplinary team or the physician.

PROTECTION OF RESIDENTS' RIGHTS

The facility shall ensure the rights of all residents. Therefore the facility shall:

A. Inform each resident, parent (if the resident is a minor), or legal guardian of the resident's rights and the rules of the facility.

B. Inform each resident, parent (if the resident is a minor), or legal guardian, of the resident's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.

C. Allow and encourage individual residents to exercise their rights as residents of the facility, and as citizens of the United States, including the right to file complaints and the right to due process.

D. Allow individual residents to manage their financial affairs and teach them to do so to the extent of their capabilities.

E. Ensure that residents are not subjected to physical, verbal, sexual, or psychological abuse or punishment.

F. Ensure that residents are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints.

G. Provide each resident with the opportunity for personal privacy and ensure privacy during treatment and care of personal needs.

H. Ensure that residents are not compelled to perform services for the facility and ensure that residents who do work for the facility are compensated for their efforts at prevailing wages and commensurate with their abilities.

I. Ensure residents the opportunity to communicate, associate, and meet privately with individuals of their choice, and to send and receive unopened mail.

J. Ensure that residents have access to telephone with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within their individual program plans.

K. Ensure residents the opportunity to participate in social, religious, and community group activities.

L. Ensure that residents have the right to retain and use appropriate personal possessions and clothing, and ensure that each resident is dressed in the resident's own clothing each day.

M. Permit a husband and wife who both reside in the facility to share a room.

The facility shall establish and maintain a system that ensures a full and complete accounting of residents' personal funds entrusted to the facility on behalf of clients and precludes any commingling of resident funds with facility funds or with the funds of any person other than another resident. The resident's financial record shall be available on request to the resident, parent (if the resident is a minor), or legal guardian.

Communication With Clients, Parents, and Guardians

The facility shall promote participation of parents (if the resident is a minor) and legal guardians in the process of providing active treatment to a resident, unless their participation is unobtainable or inappropriate. The facility shall answer communications from residents' families and friends promptly and appropriately. The facility shall promptly notify the resident's parents or guardian of any significant incidents or changes in the resident's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.

The facility shall promote visits by persons with a relationship to the resident {such as family, close friends, legal guardians and advocates) at any reasonable hour, without prior notice, consistent with the right of that resident's and other residents' privacy, unless the interdisciplinary team determines that the visit would not be appropriate. The facility shall promote visits by parents or guardians to any area of the facility that provides direct resident care services to the client, consistent with the rights of that resident and other residents' privacy.

The facility shall promote frequent and informal leaves from the facility for visits, trips, or vacations.

Staff Treatment of Residents

The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, or abuse of the resident. Staff of the facility shall not use physical, verbal, sexual or psychological abuse or punishment. Staff should not punish a resident by withholding food or hydration that contributes to a nutritionally adequate diet.

The facility shall prohibit the employment of people with a conviction or prior employment history of child or client abuse, neglect or mistreatment.

The facility shall ensure that all allegations of mistreatment, neglect, or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with state law through established procedures. The facility shall have evidence that all alleged violations are thoroughly investigated and shall prevent further potential abuse while the investigation is in progress. The results of all investigations shall be reported to the administrator or designated representative or

to other officials in accordance with state law within five working days of the incident, and, if the alleged violation is verified, appropriate corrective action shall be taken.

Safegarding Personal Property

The facility shall safeguard the resident's personal possessions. Safeguarding shall include, but is not limited to:

1. Providing a method of identification of the resident's suitcases, clothing, and other personal effects, and listing these on an appropriate form attached to the resident's record at the time of admission. These records shall be kept current. Any personal effects released to a relative of the resident shall be covered by a signed receipt.

2. Providing adequate storage facilities for the resident's personal effects.

3. Ensuring that the resident is accorded privacy and uncensored communication with others by mail and telephone and with persons of the resident's choice except when therapeutic or security reasons dictate otherwise. Any limitations or restrictions imposed shall be approved by the administrator and the reasons noted shall be made a part of the resident's record.

MEDICAID ELIGIBILITY

Eligibility for Medicaid is determined under rules established by the Department. Within certain limits established by the federal government, each state determines which health care services it wishes to provide through the Medicaid Program and which groups of people are eligible for these services. Groups of persons eligible for Medicaid in Iowa include the following:

A. Current recipients of Aid to Dependent Children and various kinds of deemed and past recipients.

B. Persons receiving a payment through the federal Supplemental Security Income (SSI) program for the aged, blind and disabled. This includes certain persons in medical institutions (hospitals and nursing facilities) who, though not receiving SSI payments while in the institution, would be eligible to receive them if living outside of the medical institution.

C. Persons who were receiving Old Age Assistance, Aid to the Blind, and Aid to the Disabled on December 31, 1973, as long as they continue to meet the eligibility conditions for Medical Assistance as of December 31, 1973.

D. Recipients of State Supplementary Assistance.

E. Persons in medical institutions who would be ineligible for SSI in their own homes because their income exceeds SSI standards, but whose income is less than 300 percent of the SSI standards for one person (the "Medicaid cap"). (This standard is indexed for inflation and changes as determined by Congress.)

F. Persons under 21 who meet the financial criteria of the Aid to Dependent Children program, but do not meet other requirements.

G. Persons who decline a Supplemental Security Income, State Supplementary Assistance, or Aid to Dependent Children grant.

H. Persons who would be eligible for SSI or State Supplementary Assistance except for cost of living increases in Social Security income received since they last received SSI or State Supplementary Assistance along with Social Security.

New coverage groups are created periodically by Congress. Federal law also provides that persons who transfer resources in order to become eligible for Medicaid generally are not eligible for Medicaid payment of nursing care facility services.

Application Procedure

Financial eligibility for Medicaid is determined by the county Department offices under rules established by the Department. Facilities should advise persons needing help with the costs of medical care to contact the Department office in the county in which they reside (or where they will reside when they enter the facility).

Persons whose monthly income indicates they would be eligible for SSI must apply for the SSI program at the district office of the Social Security Administration serving the area in which the facility is located. (After the month of entry to the facility, only persons with a monthly income less than $50 need to apply for SSI.)

Persons whose income is over SSI standards must apply to the Department. Such people, commonly referred to as persons in the "300% group," are financially eligible for Medicaid in a medical facility providing monthly income is not in excess of 300% of SSI income limits and resources are within SSI limits. Eligibility requires a 30-consecutive-day period of residence in a medical institution. A resident may have been in more than one facility during the month or needed more than one level of care but must have been in a medical institution during the 30-day period. Residents whose deaths occur during the 30-consecutive-day period of residency will be considered eligible if there was continuous residency.

The Department redetermines Medicaid eligibility for persons having monthly income of $50 or more. For persons with monthly income of less than $50, redetermination of eligibility is done by the district office of the Social Security Administration.

Eligibility for Services

Contact the Iowa Foundation for Medical Care (IFMC) on, or preferably before, admission of a resident who is expected to be financially eligible for Medicaid. Also contact IFMC when a resident who has been admitted on private pay decides to apply for Medicaid. (The IFMC reviews ICF/MR admissions and transfers only when documentation is provided which verifies a referral from a case management program.)

The initial evaluation for admission shall be conducted by an interdisciplinary team. The team shall consist of a physician, a social worker, and other professionals. At least one member of the team shall be a qualified mental retardation professional.

The evaluation shall include a comprehensive medical, social, and psychological evaluation. The comprehensive evaluation shall include:

- Diagnoses, summaries of present medical, social and where appropriate, developmental findings, medical and social family history, mental and physical functional capacity, prognoses, range of service needs, and amounts of care required.
- An evaluation of the resources available in the home, family, and community.
- An explicit recommendation with respect to admission (or in the case of persons who make application while in the facility, with respect to continued care in the facility).

  Where it is determined that ICF/MR services are required by a person whose needs might be met through the use of alternative services which are currently unavailable, this fact shall be entered in the record, and plans shall be initiated for the active exploration of alternatives.
- An individual plan for care shall include:
  - Diagnosis, symptoms, complaints or complications indicating the need for admission;
  - A description of the functional level of the resident;
  - Written objective;
  - Orders as appropriate for medications, treatments, restorative and rehabilitative services, therapies, diet, activities, social services, and special procedures designed to meet the objectives;

- Plans for continuing care, including provisions for review and necessary modifications of the plan, and discharge.

♦ Written reports of the evaluation and the written individual plan of care shall be delivered to the facility and entered in the resident's record at the time of admission or, in the case of persons already in the facility, immediately upon completion.

Medicaid-eligible persons may be admitted to an ICF/MR upon the certification of a licensed physician of medicine or osteopathy that there is a necessity for care at the facility Eligibility shall continue as long as a valid need for the care exists.

Medicaid payment will be made for ICF/MR care only upon certification of need for this level of care by a licensed physician of medicine or osteopathy and approval by the IFMC, Iowa's peer review organization.

IFMC makes the decision as to necessity for ICF/MR care and sends a printout with the pertinent data to the Bureau of Long-Term Care. The Division matches the report with financial eligibility data.

An informational copy of the printout is furnished to the facility. Facility staff should check the printout for accuracy. Any errors noted, such as a misspelling of the resident's name or the date of medical approval, should be reported to the IFMC.

No Medicaid payment can be made until the IFMC has the recipient's Medicaid identification number. Facilities can expedite prompt payment by notifying IFMC of the identification number as soon as it becomes available.

Placement Approved

When placement has final approval of the Department, payment will be authorized retroactive to the date of the resident's admission to the facility, if appropriate.

The beginning date of eligibility shall be no more than 90 days before the first day of the month in which application was filed with the Department. Eligibility can be granted retroactively for the three months before application, provided that eligibility existed at that time.

Placement Not Approved

When ICF/MR placement is not approved for medical reasons, the IFMC notifies the facility of the decision by telephone on the day that the decision is made. The facility is responsible for notifying the resident of this decision.

Written confirmation from the IFMC will follow the telephone notification of disapproval. Copies of this written notice are provided to the facility, the resident, the attending physician, and the Department.

Upon notice of disapproval, the facility should put the resident's discharge plan into effect, in cooperation with the resident and the resident's family. A county office worker will be contacting the facility to monitor the progress made in effecting the discharge plan.

Continued Stay Reviews

Continued stay reviews are the responsibility of the Iowa Foundation for Medical Care. Continued stay reviews are performed at least yearly. Their purpose is to determine if the resident continues to need the ICF/MR care.

ARRANGEMENTS MADE WITH THE RESIDENT

Some persons requiring care are able to understand the necessity for care and participate in the planning for it. Others may be unable to discuss their problems. In such cases, protective services may be necessary. Contact the county office for assistance to enable the family to make a decision as to whether guardianship should be established.

Resident Care Agreement

The ICF/MR shall enter into form 470-0374, *ICF/MR Resident Care Agreement*, with a Medicaid-eligible resident (or the resident's relative, guardian, or trustee) upon admission to the facility.

Iowa law requires that each person residing in a health care facility be covered by a contract that lists the duties, rights, and obligations of all parties. Consequently, for Medicaid residents, form 470-0374, which is a three-party contract between the facility, the resident, and the Department, is required.

Financial Participation

A resident's payment for care may include any voluntary payments made by family members toward the cost of care. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care for the month before any state payment is made.

All of a resident's income in excess of authorized exemptions is applied toward the cost of care. The resident retains $30 of income for personal needs. After the resident's financial participation is exhausted, the state makes up the difference between the resident's income and the cost of ICF/MR care for the month. The facility is responsible for collecting the resident's financial participation.

All resident income above the authorized exemption is applied to the cost of care, beginning with the first month of admission as a Medicaid resident in the following instances:

- Residents leaving the facility for the purpose of hospitalization, nursing facility care or skilled care who remain on the Medicaid program and later return to the ICF/MR.
- Residents changing from private-pay status to Medicaid status while residing in an ICF/MR.
- Residents transferring from an out-of-state ICF/MR to an Iowa facility.

A resident who has moved from an independent living arrangement to an ICF/MR may have limited first-month client participation due to maintenance or living expenses connected with the previous living arrangement. A county office worker of the Department determines how much of the resident's income may be protected in order to defray expenses.

It is essential that the resident, someone acting in the resident's behalf, or the administrator of the ICF/MR immediately notify the district office of the Social Security Administration and the county office of the Department when an SSI beneficiary enters the facility and when an SSI beneficiary is discharged. (The county office is notified by means of form 470-0042, *Case Activity Report*.)

This is necessary so that incorrect SSI payments can be avoided and overpayments or underpayments through the Medicaid Program do not occur.

If a resident transfers from one ICF/MR to another during a month, any remaining financial participation shall be taken to the new facility and applied to the cost of care at that facility. Present policy concerning differential payment for reserve bed days may change the use of financial participation when residents are absent from the facility. (See the section on absence from the ICF/MR.)

Administrators should ensure that the correct amount of financial participation is collected, particularly in cases where the resident may transfer from the facility.

The worker at the county office determines client participation. The amounts of first-month and ongoing financial participation are shown on form MA-2l39-0, *Facility Card*.

Medicare, Veterans, and Similar Benefits

All medical resources available to the resident must be used to pay for the cost of the resident's ICF/MR care. Such resources include private health or accident insurance carried by the resident, or by others on the resident's behalf, trusts set up for medical care, and services reasonably available through other publicly supported programs, such as Medicare, veterans benefits, Vocational Rehabilitation, etc.

When a facility receives information that not all resources available to a resident are being used, notify the county office of the Department in writing. Following is a suggested format:

To: _____ County Department of Human Services

From: _____ (Name of Facility)

Subject: _____ (Recipient's Name)

We have received information that this resident may:

___ Be eligible for veterans benefits

___ Have other potential resources to pay for care as described below:

___ Not be eligible for Medicaid because:

cc: Iowa Department of Human Services
Bureau of Long-Term Care
1305 E Walnut Street, 5th Floor
Des Moines, IA 50319-0114

Personal Needs Allowance

All Medicaid residents of an ICF/MR have a small income which is intended to cover the purchase of necessary clothing and incidentals. This is called the personal needs allowance.

If the resident has personal income, the first $30 of income is retained for these personal needs and an additional amount up to $65 is allowed from earned income only. If the resident's income is less than the personal needs allowance, the difference between the income and the personal needs allowance is usually paid to the resident through the Supplemental Security Income Program.

As its name suggests, the personal needs allowance is an allotment of money provided for the resident to spend on such personal needs and articles as the resident wishes. To the extent feasible, the resident should be encouraged to see the money as personal funds. If the resident is unable to manage personal funds, the guardian should then use the allowance to meet the personal needs of the resident.

The resident is to be the person who is to be spending the money, and the resident should be encouraged to see the money as his or her personal funds. If the resident is unable to manage funds, the guardian should then use the allowance to meet the personal needs of the resident.

The personal needs allowance is seen as one method of improving the quality of life for those persons needing an ICF/MR living situation. The money can serve as a way for the resident to maintain control over a segment of personal life and environment, and a way for the resident to individualize himself or herself in an institutional setting.

No Medicaid resident or responsible party shall be charged for items not specifically requested by the resident or responsible party. The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare.

Policy concerning the responsibility for payment of nonlegend drugs and for payment of certain legend drugs not payable through Medicaid is sometimes misinterpreted by facilities and the general public. The main points of the Department's long-standing policy in this area are as follows:

1. If a physician prescribes a nonlegend drug by brand name, the facility is expected to provide that particular brand to the resident. The expense is shown as an audit cost to the facility.

2. If a physician does not specify a brand name in an order for a nonlegend drug, it is proper that the facility offer a house brand stocked by the facility. If a resident insists upon other than the house item, it is always the responsibility of the facility to make the first offer to provide any nonlegend drug prescribed by a physician.

3. A physician may order a prescription drug for which the Medicaid program will not make payment, since the drug is on the list of products classified by the Food and Drug Administration as lacking adequate evidence of effectiveness.

   If so, the physician and resident shall be advised that Medicaid does not pay for the item and that the facility cannot accept responsibility for payment, since such noncovered drugs are not to be shown as an audit cost on the financial and statistical report. If the physician or the resident insists on the item in question, it becomes the responsibility of the resident or a responsible third party to deal with the pharmacy providing the drug.

If the personal needs fund exceeds the Medicaid eligibility limit, the person loses Medicaid eligibility until resources are within this limit as of the first moment of the first day of a month.

MEDICAID BILLING AND PAYMENT

Method of Reimbursement

The Medicaid program reimburses ICFs/MR under a cost-related vendor payment system, with a per diem set for each facility. This rate is established on the basis of financial and statistical data submitted by the facility on form 470-0030, *Financial and Statistical Report*. The financial data submitted by the facility is audited by the accounting firm under contract with the Department.

Rate Determination

a. Business Startup and Organization Costs

The costs incurred during the period of developing a provider's ability to furnish patient care services are referred to as start-up costs. Since these costs are related to patient care services rendered after the time of preparation, the costs must be capitalized as deferred charges and amortized over a five-year period.

Start-up costs include, for example, administrative and program staff salaries, heat, gas and electricity, taxes, insurance, mortgage and other interest, employee training costs, repairs and maintenance, and housekeeping. Any other costs that are properly identifiable as organization costs or capitalizable as construction costs must be appropriately classified as such.

Organization costs are those costs directly incident to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges which have a value to the enterprise. The services inherent in organization costs extend over more than one accounting period and affect the cost of future periods of operation. Organization costs must be amortized over a five-year period.

Allowable organization costs include, but are not limited to, legal fees incurred in establishing the corporation or other organization (such as drafting the corporate charter and bylaws, legal agreements, minutes of organization meetings, terms of original stock certificates), necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders, and fees paid to states for incorporation.

The following types of costs are not considered allowable organization costs: costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters' fees and commissions, accountant's or lawyer's fees; costs of qualifying the issues with the appropriate state or federal authorities; and stamp taxes.

b. Administrative Costs

Administrative costs shall not exceed 18 percent of total facility costs. Administrative costs are comprised of those costs incurred in the general management and administrative functions of the facility. Administrative costs include, but are not necessarily limited to, the following:

(1) Administrative salaries.
(2) Accounting costs.
(3) Clerical costs.
(4) Data processing.
(5) Personnel department.
(6) Management fees.
(7) Home office and other organizational costs.
(8) Office supplies and postage.
(9) Indirect business expense.

c. Actual Allowable Cost Per Diem

The actual allowable cost for ICFs/MR shall be the actual audited reported cost plus the inflation factor and may include an incentive factor.

For community-based ICFs/MR, an additional occupancy factor is used in determining the actual per diem rate for the facility. Typically the per diem is arrived at by dividing the actual allowable reported costs by total patient days during the reporting period.

Total patient days for purposes of rate determination shall be actual inpatient days or 80 percent of the licensed capacity of the facility, whichever is greater.

d. Inflation Factor

The inflation factor is equal to the lesser of the percentage increase of the Consumer Price Index for all urban consumers, U.S. city average, or the average percentage increase of actual costs from the prior year, of "Unaudited Compilation of Various Costs and Statistical Data." The inflation factor is applied to the first six months and all subsequent cost reports submitted by a new ICF/MR and the annual cost reports for the existing ICFs/MR.

e. Incentive Factor

An incentive factor for new facilities is applied to the first six- month cost report files ending June 30 after a base rate has been established. The incentive factor for existing ICFs/MR is applied annually.

Facilities with a per diem cost percentage increase of less than the percentage increase of the Consumer Price Index are given their actual percentage increase plus one-half the difference of the Consumer Price Index less their actual percentage increase. This percentage difference times the actual per diem cost for the annual period just completed is the incentive factor.

Facilities whose annual per diem cost decreased from the prior year are given one-half the percentage increase in the Consumer Price Index as an incentive for cost containment. One-half of the percentage increase of the Consumer Price Index times the actual per diem cost for the annual period just completed is the incentive factor.

f. Maximum Allowable Base Rate

The maximum allowable base rate for the first annual period is determined by taking the per diem rate calculated for new facilities for the base period and then multiplying it by the Consumer Price Index and adding it to the base rate. The maximum allowable base rate for each period thereafter (until rebasing) is calculated by increasing the prior year's maximum allowable base by the annual percentage increase of the Consumer Price Index for all urban consumers, U.S. city average.

Facility rates will be rebased using the cost report for the year covering state fiscal year 1996 and will subsequently be rebased each four years. The Department will consider allowing special rate adjustments between rebasing cycles if:

(1) An increase in the minimum wage occurs.

(2) A change in federal regulations occurs which necessitates additional staff or expenditures for capital improvements, or a change in state or federal law occurs, or a court order with force of law mandates program changes which necessitates the addition of staff or other resources.

(3) A decision is made by a facility to serve a significantly different client population or to otherwise make a dramatic change in program structure. (Documentation and verification will be required.)

(4) A facility increases or decreases licensed bed capacity by 20 percent or more.

g. Maximum Allowable Cost Ceiling

The maximum allowable cost ceiling is set at the eightieth percentile of all participating community-based Iowa ICFs/MR based on the "Unaudited Compilation of Various Costs and Statistical Data." The eightieth percentile maximum rate is adjusted July 1 of each year. The state hospital schools are not included in the compilation of facility costs.

h. Reimbursement Rate (Payment Rate)

The reimbursement rate is the lower of the actual allowable per diem rate, the maximum allowable based rate, or the maximum allowable cost ceiling.

Payment to New Facility

a. Budget

A facility receiving initial Medicaid certification for ICF/MR level of care shall submit a budget for six months of operation beginning with the month in which Medicaid certification is given. The budget shall be submitted at least 30 days in advance of the anticipated certification date.

The Medicaid per diem rate for a new facility is based on the submitted budget, subject to review by the accounting firm under contract with the Department. The rate is subject to the maximum allowable cost ceiling. The beginning rate for a new facility is effective with the date of Medicaid certification.

b. First Six Months

Following six months of operation as a new community-based Medicaid-certified ICF/MR, the facility shall submit a report of actual costs. This financial and statistical report establishes a rate which may include inflation but will not include an incentive. The rate computed from this cost report is adjusted to 100% occupancy and continues to be subject to the maximum allowable cost ceiling.

c. Second Six Months (Base Rate)

Following the first 12 months of operation as a Medicaid-certified ICF/MR, the facility shall submit a cost report for the second six months of operation. The accounting firm under contract with the Department will perform an on-site audit of facility costs.

Based on the audited cost report, a rate will be established for the facility. This rate will be the facility's base rate until rebasing of facility costs occurs. The reimbursement rate for the second six months cost report is subject to the lower of the maximum allowable cost ceiling, the actual allowable per diem rate, or the maximum allowable base rate.

d. Subsequent Reports

After the second six months of operation and in order to bring the facility reporting cycle to a June 30 reporting period, facilities must submit cost reports based on the following:

- Facilities receiving initial certification between July 1 and December 31 shall submit three successive six-month cost reports covering three first 18 months of operation. The fourth six-month cost report shall cover the January 1 to June 30 period. Thereafter, the facility shall submit a cost report on an annual basis of July 1 to June 30.
- Facilities receiving initial certification between January 1 and June 30 shall submit two successive six-month cost reports covering the first 12 months of operation. The third six-month cost report shall cover the January 1 to June 30 period. Thereafter, the facility shall submit a cost report on an annual basis of July 1 to June 30.

The reimbursement rate for all subsequent cost reports is the lower of the maximum allowable cost ceiling, the actual allowable per diem rate, or the maximum allowable base rate.

Payment to New Owner

An existing facility with a new owner shall continue with the previous owner's per diem rate until a new financial and statistical report has been submitted and a new rate established. The facility shall submit one report for the period of July 1 to June 20. A new base rate will not be established because of a change in ownership.

Payment to Existing Facilities

The following reimbursement limits apply to all nonstate-owned ICFs/MR:

- The facility's cost report covering the period from January 1, 1992, to June 30, 1992, is used to establish the base allowable cost per unit to be used in future reimbursement rate calculations. Subsequent cost reports shall be filed annually covering the 12 months from July 1 to June 30.
- The reimbursement rate established based on the report covering January 1, 1992, to June 30, 1992, is calculated using the method in place before July 1, 1992, including inflation and incentive factors.
- The reimbursement rate is the lower of the actual allowable per diem rate, the maximum allowable base rate, or the maximum allowable cost ceiling.

State-owned ICFs/MR shall submit semiannual cost reports. They receive semiannual rate adjustments based on actual costs of operation inflated by the percentage change in the Consumer Price Index, all urban consumers, U.S. city average.

Out-of-State Facilities

Payment will be made for care in out-of-state ICFs/MR. Out-of-state facilities shall abide by the same policies as in-state facilities, with the following exceptions:

- Out-of-state providers will be reimbursed at the same rate they are receiving from their state of residence subject to the maximum allowable cost ceiling.
- Out-of-state facilities shall not submit financial and statistical reports.
- Payment for periods when residents are absent for visits of hospitalization will be made to out-of-state facilities at 80 percent of the rate paid to the facility by the Iowa Medicaid program. Out-of-state facilities with 15 or fewer beds shall be reimbursed at 95 percent of the rate paid to the facility by the Iowa Medicaid program.

Billing Procedures

Nursing facility claims for payment are processed by the Department's fiscal agent, currently ACS, Inc. Facilities can submit claims either on form 470-0039, *Iowa Medicaid Long-Term Care Claim*, or electronically.

Claims can be submitted electronically through software provided at no charge by ACS. To request this software, referred to as ASAP, facilities should contact the EDI Coordinator at ACS Inc., PO Box 14422, Des Moines, IA 50306-3422. Facilities will receive ASAP diskettes and an instruction manual that explains how to install the software.

At the end of each month, facilities that do not submit claims electronically are sent form 470-0039, referred to as a "TAD" or "Turn-Around Document." The form lists information on Medicaid recipients who department records show to be at the facility. See Appendix A for an explanation of each field on this form.

Any residents who had leave days (covered or noncovered), or who were discharged during the billing month should be noted in red in the appropriate fields on the TAD. No changes need to be noted if the client did not have leave days or was not discharged during the month.

If the facility needs to resubmit a claim, the facility must use a blank TAD and complete the appropriate fields. Blank TADs can be requested through the fiscal agent. Notation should be made on the form that it is a resubmission of a previous claim.

TADs must always be signed before sending them to the fiscal agent.

Time Frames for Submitting Claims

Claims can be submitted any time during the month for the previous month. However, for residents who are in the facility all month, only one claim should be submitted per month after the end of the month.

Payment will be made for covered services when the fiscal agent receives the initial claim within one year from the date of services. Claims submitted beyond the one-year limit may be paid only when they are delayed due to delays in receiving third-party payments or retroactive eligibility determinations.

The fiscal agent generates payments weekly, and mails checks every Wednesday.

Remittance Statements

After claims have been processed by the fiscal agent, the facility is sent a *Remittance Advice*. The *Remittance Advice* is also available on magnetic computer tape for automated accounts receivable posting. See Appendix A for an explanation of this form.

The *Remittance Advice* is separated into categories that show the status of the claims that follow. The categories are:

- Paid indicates all processed claims, credits and adjustments for which there is full or partial payment.
- Denied represents all processed claims for which no reimbursement is made.

Suspended reflects claims that are currently in process pending resolution of one or more issues, i.e., third-party benefit determinations, eligibility decisions, (etc.)

Suspended claims may or may not print depending on which option the facility chooses. Facilities can choose one of the following options:

- Print suspended claims only once.
- Print all suspended claims until paid or denied.
- Do not print suspended claims.

Facilities can change which option they would like by contacting Provider Enrollment at ACS.

Making Adjustments to Previously Submitted Claims

To make an adjustment to a claim following receipt of the *Remittance Advice*, facilities use form 470-0040, *Credit Adjustment Request*. These forms can be obtained by contacting the fiscal agent. See Appendix A for an explanation of the fields on the form.

Submit a *Credit/Adjustment Request* to notify the fiscal agent that a paid claim amount needs to be changed, that money needs to be credited back, or that an entire remittance statement should be canceled. This form is **not** used when a claim has been denied. Denied claims must be resubmitted.

Fiscal Agent Address and Telephone Numbers

Submit claims to:

ACS, Inc.
P.O. Box 14421
Des Moines, IA 50306-3421

Send all other correspondence relating to billing and payment to:

ACS, Inc.
P.O. Box 14422
Des Moines, IA 50306-3421

Questions regarding billing and payment issues are handled by:

Provider Relations
Local: 515-327-5120
Toll-free: 800-338-7909
(7:00 a.m. to 5:00 p.m., M-F)

Facilities can enroll in the Medicaid program or make changes in enrollment information by calling Provider Enrollment at the above number.

Periods of Service for Which Payment Will Be Authorized

Payment for care in an ICF/MR is authorized to begin on the date that the resident is certified as medically needing that level of care and is otherwise financially eligible for Medicaid. It can continue as long as both of these criteria are met and the resident remains in care.

If only a distinct part of the total facility has been certified as an ICF/MR, payment may be approved through the Medicaid program only for residents who occupy beds in the certified part of the facility. The facility shall not submit claims to the state nor request authorizations from the Department for residents who do not receive care in the certified part of the facility.

Payment for care in an ICF/MR is made on a per diem basis for the portion of the month the resident is in the facility. Payment is made for the day of admission but not the day of discharge or death. No payment shall be made for care of persons entering and leaving the facility the same day. If there is excess client participation because the resident leaves the facility early in the month, the facility must refund the excess to the resident.

Under certain conditions, a facility may receive Medicaid payments for days that a resident is absent for visits or hospitalization. The facility shall report all resident absences to the county office using form 470-0042, *Case Activity Report*.

Absence for Visits

Payment will be approved for periods the resident is absent to visit home for a maximum of 30 days annually. These 30 days be taken at any time. There is no restriction as to the amount of days taken in any one month or on any one visit, as long as the days taken in the calendar year do not exceed 30. Visit days shall not be used to extend payment for hospital stays. The resident must intend to return to the facility.

Additional days may be approved for special programs of evaluation, treatment, or habilitation outside the facility. Documentation as to the appropriateness and therapeutic value of resident visits and outside programming, signed by a physician or qualified mental retardation professional, shall be maintained at the facility.

Absence for Hospitalization

Payment will be approved to hold the bed while the resident is hospitalized (not in a skilled bed) for a period not to exceed ten days in a calendar month, as long as the resident intents to return to the facility. However, if the person enters a mental health institute, this provision no longer applies. Payment will not be made for over ten days per month.

For example, a resident enters the hospital on September 21 and is discharged on October 14. The resident then reenters the hospital on October 18 and is discharged October 31. For the first hospitalization, Medicaid pays to hold the bed for the 10-day period of September 21-30. The 10 days renews in October. In the second month, Medicaid pays to reserve the bed for the period of October 1-10 (10 days). The periods of October 11-14 and October 18-31 are not covered due to the 10-day limit in any one month.

Note: Payment for reserving a bed is made only when a resident was admitted before the absence. No payments are made to reserve a bed in a facility to which a resident intends to transfer.

Payment Rate for Reserved Beds

Medicaid payments for reserved bed days in an ICF/MR of over 15 beds are made at the rate of 80% of the allowable audited cost (facility costs plus any added factors). Facilities with 15 or fewer beds are reimbursed at 95% of the allowable audited cost for reserved bed days. This extra reserve bed payment is not handled through the automated billing system. These facilities must notify county Department staff to do a vendor adjustment to issue this payment.

Since the reserved bed payment rate has the result of changing the financial participation in some cases, administrators must ensure that the correct amount of financial participation is collected. This is particularly important where a resident leaves the facility and is due a refund on financial participation previously collected.

Payment After Medical Eligibility Denial

The Department is bound by medical review determinations performed by the peer review organization (PRO). The Department is not authorized to pay for ICF/MR services provided to persons who do not satisfy PRO medical eligibility criteria, even if the person is financially eligible. However, in certain cases, the Department continues limited Medicaid coverage after PRO medical eligibility denial.

a. **Grace Days.** Financially eligible persons who are (or would be) new admissions to an ICF/MR and are medically denied by the PRO are not eligible for ICF/MR service payment from Medicaid. Medicaid recipients in ICFs/MR who receive "continued stay" medical denials may be eligible for a grace-day period of up to 30 working days.

If the facility and county service worker reports document that no appropriate, alternate placement is available within a reasonable distance, this grace period may be extended until alternate placement becomes available. Extension of grace days beyond the standard 30 working days is a joint determination of the Bureau of Long-Term Care and PRO liaison personnel.

b. **Continuation of Other Medicaid Services**. Even if the PRO has denied a Medicaid recipient for ICF/MR service, the person may still be eligible to receive other Medicaid services if the person would be eligible for SSI if still at home.

Presuming that some other payment source is available to maintain the SSI-eligible resident at the ICF/MR, other covered medical services can be reimbursed through other Medicaid vendors, such as physicians, pharmacies, medical appliance dealers, etc.

ICF/MR residents who would not be eligible for SSI if still in their own homes may be ineligible for Medicaid if they are medically denied by the PRO, or they may be eligible for partial Medicaid benefits.

Supplementation

Medicaid rules prohibit supplementation of the Medicaid payment for care in an ICF/MR. Only the amount of client participation may be billed to the resident. No supplementation of the state payment shall be made by any person. Practices such as charging residents or their families extra money for a private room are considered to be supplementation and are not permissible, even if the payment is offered voluntarily.

Exceptions:

1. A resident, the family, or friends shall be allowed to pay a facility to reserve a resident's bed beyond the maximum number of reserve bed days that the Department pays or allows to be paid from client participation. When a resident is not discharged, payments shall not exceed 80 percent of the allowable audited costs for the facility, not to exceed the maximum reimbursement rate.

   However, facilities which discharge resident after the date the state discontinues payment may make arrangements with the resident or family to hold the bed at whatever rate is agreed upon by both parties. Facilities must make arrangements with residents or their families to reserve beds in advance of the date when the reserve bed days run out and the resident is billed for the bed.

2. There are cases when a family member or other interested person wishes to make an ongoing voluntary contribution toward the cost of care of a Medicaid resident. Such payments shall not be considered as supplementation, so long as they increase the resident's client participation and are not over and above the payment made by the state for care or the resident.

   Form 470-0373, *Voluntary Contribution Agreement*, may be used to implement such a voluntary contribution. (See the Appendix)

ICF/MR Provider Assessment Fee

As required by Iowa Code section 249A.21, licensed ICFs/MR certified to participate in the Medicaid program that are not operated by the state are obligated to pay a monthly assessment fee to the Department.

The amount of the provider assessment fee is 6% of the facility’s total annual revenue for the preceding fiscal year, divided by the number of months of operations during the preceding fiscal year.

The assessment fee is calculated based on information reported on the facility's *Financial and Statistical Report* for the most recent fiscal year end.

The Department will increase each facility's Medicaid rate by an amount equal to 6% of the total annual revenues for the preceding fiscal year to account for the provider assessment fee. The increase in Medicaid rates is effective upon implementation of the provider assessment fee.

Each year following the submission and review of the *Financial and Statistical Report*, the Department or its contractor will notify each facility of the amount of monthly assessment fee that is due.

The assessment fee is subject to adjustment based on any adjustments made to the financial and statistical reports. The Department will deduct each facility's monthly provider assessment fee from their monthly medical assistance payments.

TRANSFER AND DISCHARGE

If a resident is to be either transferred or discharged, the facility shall have documentation in the resident's record that the resident was transferred or discharged for good cause. The facility shall provide a reasonable time to prepare the resident and the resident's parents or guardian for the transfer or discharge (except in emergencies).

A transfer or discharge from an ICF/MR should be planned as carefully and thoroughly as an admission to the facility. It is desirable that the resident and the facility staff achieve understanding about the resident's current needs, condition, and programs, and the probable duration of stay in the ICF/MR. Such understandings make for better morale and adjustment to facility life on the part of the resident, and are particularly important to good transfer and discharge planning.

Good transfer and discharge planning begins at the time of the resident's admission and continues during the stay in the facility. Such planning involves gathering information, much of which should be available from the social history completed at the resident's admission.

Important considerations include the resident's medical condition and prognosis, family support system, previous living arrangement, and the resident's preferred living arrangement. Based on these factors, a preliminary analysis of alternatives for the resident is used to develop a discharge plan, which is subject to revision as the resident's condition changes.

For a resident whose condition is improving, the plan shall be made progressively more specific and time-limited. If a resident's condition becomes worse, the plan may need to be deferred, or even suspended in an irreversible case.

Consequently every resident's situation must be periodically reviewed to assess the effectiveness of the current plan in response to individual needs.

The facility social worker is the interdisciplinary team member responsible for coordination. As such, the social worker is the staff person in the best position to conduct these reviews and monitor progress toward achievement of objectives which will make eventual discharge possible. This requires good communication channels with the resident, the family, the physician, and others involved with the resident.

The facility social worker must be aware of what community resources are available to assist the resident in making a successful transfer to a different living arrangement. The county office of the Department is a useful informational resource in this last regard, but primary responsibility for discharge planning remains with the ICF/MR.

In the event of a forced moved, such a revocation of license or Medicaid certification, fire or other disaster, discharge assistance will be furnished by the Department.

The Department will also assist in particularly difficult or complex cases where the facility has been unsuccessful in arranging an appropriate alternative. But in most cases, the Department expects that the ICF/MR possesses the necessary information and professional resources to coordinate discharge planning efforts effectively.

Reasons for Discharge or Transfer

A Medicaid resident may be **involuntarily** discharged from an ICF/MR only if one of the following conditions exists:

- Discharge is necessary for medical reasons.
- The resident must be discharged for the resident's welfare or for the welfare of other residents.
- The resident does not make payment for ICF/MR care (client participation).

Other instances where a resident may be discharged or transferred include the following:

- The resident wants to leave the facility. In the absence of a guardianship or other legal restraint, the resident may do so upon request.
- The resident's physician or family requests transfer or discharge. With agreement by the resident, this must then be done.
- The resident's guardian or other legal representative may request it.

- A finding that ICF/MR care is no longer medically necessary may terminate Medicaid payments, causing a person to seek other living arrangements for financial reasons.
- Death of the resident, closing or sale of the facility, fire, remodeling, revocation of license, etc.

Administrative Procedures

At the time of the discharge, the facility shall develop a final summary of the resident's developmental, behavioral, social, health and nutritional status.

With the consent of the resident, parents (if the resident is a minor) or legal guardian, the facility shall provide a copy to authorized persons and agencies. The facility shall also provide a post-discharge plan of care that will assist the resident to adjust to the new living environment.

In the event that a resident is transferred to another health facility, transfer information should be summarized from the facility's records in a copy to accompany the resident. This information should include:

- A transfer form of diagnosis
- Activities of daily living information
- Transfer orders
- Nursing care plan
- Physician's orders for care
- The resident's personal record
- The resident's personal needs fund record

If a Medicaid recipient requests transfer or discharge, or there is another person requesting this for the resident, the facility administrator shall promptly notify the county office of the Department by means of 470-0042, *Case Activity Report*.

This should be done in sufficient time to permit a county office worker to assist in the decision and planning for the transfer or discharge, if needed. This also allows the county office enough time to complete the necessary paperwork, assuring a smooth discharge or transfer for the resident.

When a resident leaves the ICF/MR during the month, any unused portion of the resident's income must be refunded. The following example illustrates the procedure used in calculating refunds due the resident:

> Mr. S has monthly client participation of $300. The facility in which Mr. S resides has a per diem rate of $100. In a normal month, Mr. S pays for the first three days of his care ($100 x 3 days = $300) and the state pays for the remainder of the month.

If Mr. S leaves the facility on the third of the month, the facility must make a $100 refund to Mr. S ($300 minus $200 (2 days' care) equals $100). If he leaves the home on the fourth of the month or later, no refund is normally due. An exception could arise if reserve bed days are involved.

Department Procedures

When an ICF/MR notifies the county office by means of form 470-0042, *Case Activity Report*, that a resident has been discharged (through death, return to own home, etc.), the income maintenance worker must enter the necessary information to close the Medicaid ICF/MR case through the computer system.

This information is forwarded to the Department's central office. Form MA-2l39-0, *Facility Card*, is generated to verify the action.

When a resident is transferred to another Medicaid facility within the county, the income maintenance worker enters the necessary information concerning the transfer. This information generates form MA-2l39-0, *Facility Card*, which is sent to the gaining facility.

The county of responsibility retains the income maintenance case of an ICF/MR recipient upon transfer, except in cases involving state resource center placement. "State cases" (lacking a county of responsibility) must be transferred to the income maintenance worker in the county where the facility is located, except in cases involving state resource center placement.

Transfer of Residents by Ambulance

In some emergency cases, such as the closing of a facility or the loss of Medicaid certification by a facility, residents must be transferred from one facility to another by ambulance. Arrangements can be made to pay for this service through the Medicaid program.

Before transfer by ambulance, a worker from the county office of the Department must provide the Bureau of Long-Term Care with the information necessary to process the claim and authorize the Medicaid fiscal agent to make payment. Close coordination between the Bureau of Long-Term Care, county offices, and facilities will be requiured in all emergency situations.

Closing of Facility

The contract between the Department and an ICF/MR requires a 60-day notice before closing. Administrators planning or considering closing a facility should notify their county Department office and the Bureau of Long-Term Care as soon as possible. The moving of residents often takes longer than expected. Sufficient notice can ease the problem considerably.

We suggest that the administrator and the county office confer about the closing and together make plans so that the goal for closing can be accomplished in a smooth manner.

Facilities should not make their own plans to move residents. Those residents receiving care under Medicaid are a financial responsibility of the Department. All plans for these people must be approved by the county office.

The county and regional offices of the Department will help in planning for moving into or out of facilities. These services are available to all Medicaid residents and to other residents on request.

AUDITS OF BILLING AND HANDLING OF RESIDENT FUNDS

Upon proper identification, field auditors of the Department of Inspections and Appeals or representatives of the Department of Health and Human Services shall have the right to audit billings to the Department and receipts of client participation. The audit shall ensure that the facility is not receiving payment in excess of the contractual agreement and that all other aspects of the contractual agreement are being followed.

Upon proper identification, field auditors of the Department of Inspections and Appeals or representatives of Health and Human Services shall have the right to audit records of the facility to determine proper handling of personal needs funds.

The resident or family shall not be charged for such items as chux, toilet paper, hospital gowns, or other maintenance items, since these items are properly included in the computation of the audit cost.

The Department reserves the right to charge back to the facility any maintenance items that are charged to the resident's personal needs account when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may be charged back to the facility.

On the auditor's recommendation, the Department shall request repayment of sums inappropriately billed to the Department or collected from the resident. Repayment shall be made by the facility either to the Department or to the resident involved.

The facility has 60 days to review the audit and repay the requested funds or present supporting documentation which shows that the requested refund amount, or part of it, is not justified.

When the facility fails to comply, the requested refunds may be withheld from future payments to the facility. The withholding shall not be more than 25% of the average of the last six monthly payments to the facility. The withholding shall continue until the entire refund is recovered.

In the event the audit results indicate significant problems, they may be referred to the attorney general's office for whatever action is appropriate.

When exceptions are taken during an audit which are similar to the exceptions taken in a prior audit, the Department may, after considering the seriousness of the exceptions, reduce payment to the facility to 75% of the current payment rate.

APPEALS OF ADVERSE ACTIONS

Any action of the Department with respect to the facility (not the client) which an ICF/MR believes is unwarranted or incorrect may be appealed to the director of the Department. If the appeal involves a particular client, the client must appeal, but may be helped by the facility or any other interested person.

This appeal process should be used only after exhausting normal administrative processes. Any person or facility wishing to appeal a Department action or decision must do so within 30 days of notification of the action or decision. Appeal requests should be directed to the office taking the action.

Information concerning appeals may be obtained by contacting the Department appeals liaison at the Department of Human Services, Appeals Section, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

When the Department takes a decertification action for reasons unrelated to the survey report. the appeal is filed with the Department. The hearing is held by the Department of Inspections and Appeals, but the final decision is issued by the Department of Human Services.

Appeals of decertification actions not initiated by the Department are handled differently from other appeal proceedings. When the Department of Inspections and Appeals has surveyed a facility and found the facility to be in substantial noncompliance with Medicaid rules, the Department of Human Services may deny continued program certification. For decertification, the following conditions apply:

- When decertification is contemplated, the Department of Human Services shall send timely and adequate notice to the facility.
- Request for a hearing shall be made to the Department of Inspections and Appeals within 15 days of the notice of decertification.
- At any time before or after an evidentiary hearing, the Department of Inspections and Appeals will be willing to negotiate an amicable resolution or discuss the possibility of settlement with the facility owner.
- When a final decision is issued, that decision is binding upon the Department of Human Services.

APPENDIX A: FORMS

PROCUREMENT, INITIATION, AND DISPOSITION OF MEDICAID FORMS

FORM	INITIATED BY	DISPOSITION
470-0030 Financial and Statistical Report	Facility (three copies) (Print supply from on-line manual)	Keep one copy and send two copies to DHS Bureau of Long-Term Care.
470-0039 Iowa Medicaid Long-Term Care Claim	Fiscal agent (two copies)	Keep one copy and send one to the fiscal agent.
470-0040 Credit/Adjustment Request	Facility (Print supply from on-line manual)	Send to fiscal agent.
470-0041 Adjustment to Facility Payment	DHS county office (three copies) (	DHS county office keeps one copy and sends one copy to Quality Assurance and one copy to the facility.
470-0042 Case Activity Report	Facility (three copies) (Order form Iowa Prison industries)*	See instructions on back of form.
470-0254 Institutional Medicaid Provider Application	Facility (one copy) (Obtain from DHS Bureau of Long-Term Care)	Complete and return to Bureau of Long-Term Care
470-0372 ICF/MR Provider Agreement	DHS Bureau of Long-Term Care (two copies)	Keep one copy; return signed copy to DHS Bureau of Long-Term Care.
470-0373 Voluntary Contribution Agreement	DHS county office (three copies) (Print from manual)	Contributor, DHS county office, and facility each get a copy.
470-0374 ICF/MR Resident Care Agreement	DHS county office (three copies)	Return all copies to DHS county office for DHS signature. County office keeps one copy and returns one copy to facility.

* Order from Iowa Prison Industries, 406 N. High St., Anamosa, Iowa 52205, phone 1-800-432-9163.

PROCUREMENT, INITIATION, AND DISPOSITION OF MEDICAID FORMS (Cont.)

FORM	INITIATED BY	DISPOSITION
470-0375 ICF/MR Placement Statement	DHS county office (four copies)	All copies are sent to the Bureau of Long-Term Care, for signature. Returned to: ICF/MR, DHS county office, county board of supervisors.
470-0377 Nondiscrimination Compliance Review	DHS Bureau of Long-Term Care (two copies)	Facility returns one completed copy to DHS Bureau of Long-Term Care and keeps one copy.
470-1911 Medicaid Assistance Eligibility Card (Fee for Service)	DHS Data Management Division	Up to four cards are printed on a sheet and mailed to facility address.
HCFA-1513 Disclosure of Ownership and Control Interest Statement	DIA Health Facilities Division	As directed by DIA.
HCFA-2567B Post Certification Revisit Report	DIA Data Management Division	As directed by DIA.
HCFA-2567L Statement of Deficiencies and Plan of Correction	DIA Health Facilities Division	As directed by DIA.
HCFA-671 Long Term Care Facility Application for Medicare and Medicaid	DIA Health Facilities Division	As directed by DIA.
MA-2139-0 Facility Card	DHS Data Management Division	Keep one copy and send one to DHS county.
Remittance Advice	Fiscal agent	Maintain for your records.

INSTITUTIONAL MEDICAID PROVIDER APPLICATION, 470-0254

The Bureau of Long-Term Care uses form 470-0254 to obtain data necessary to assign a Medicaid vendor number. The facility shall request the form from the Bureau of Long-Term Care, complete it, and return it to the Bureau. This form is completed at the initial request for Medicaid certification.

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID, HCFA-671

The Department of Inspections and Appeals uses form HCFA-671 to obtain information regarding the services the facility intends to provide. The facility completes the form at the initial request for Medicaid certification and upon each survey of the facility.

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT, HCFA-1513

Form HCFA-1513 identifies the owners, board of directors, and corporate structure of the facility. The facility completes the form at the initial request for Medicaid certification and upon each survey of the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, HCFA-2567L

The Department of Inspections and Appeals and the Fire Marshall uses form HCFA-2567L to identify deficiencies of the facility and to give the facility an opportunity to explain how the deficiencies will be corrected. The form is issued after every survey of the facility.

POST CERTIFICATION REVISIT REPORT, HCFA-2567B

The Department of Inspections and Appeals and the Fire Marshall uses form HCFA-2567B to identify the fact that the deficiencies have been substantially corrected. The form is issued when DIA or the Fire Marshall revisits a facility to follow up on a survey report.

ICF/MR PROVIDER AGREEMENT, 470-0372

The provider agreement describes the terms and conditions for participation in the Medicaid program. The facility must be recommended for certification as a nursing facility before a provider agreement may be issued. The agreement must be signed by DHS and the facility.

The agreement must be completed at the beginning of every Medicaid certification period and whenever there is a change of ownership of the facility.

NONDISCRIMINATION COMPLIANCE REVIEW, 470-0377

Federal regulations require that Medicaid providers be in compliance with the Civil Rights act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended; and the Age Discrimination Act of 1975, as amended.

All facilities are required to complete form 470-0377 upon initial certification as a Medicaid provider and at each recertification to document compliance with these laws.

The Department furnishes two copies of form 470-0377 to new providers at the time of their initial request for enrollment as a Medicaid provider. Once enrolled in the Medicaid program, facilities will receive two copies of the form at the beginning of each certification period, along with the Provider agreement.

The provider shall keep one completed copy and return the other to the Bureau of Long-Term Care. Department representatives will periodically verify that the form is on hand and that the information is accurately reported.

Racial/ethnic group identification as defined by the Equal Employment Opportunity Commission is as follows:

White (not of Hispanic origin)	All persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.
Hispanic	All persons of Mexican, Puerto Rican, Cuban, or South American, or other Spanish culture or origin, regardless of race.
Black (not of Hispanic origin)	All persons having origins in any of the Black racial groups of Africa.
American Indian or Alaskan Native	All persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.
Asian or Pacific Islander	All persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. These areas include, for example, China, Japan, Korea, the Republic of the Philippines, and Samoa.

NONDISCRIMINATION COMPLIANCE REVIEW, 470-0377 (Cont.)

As defined in the Section 504 regulations, a person with disabilities is any person meeting one of the following:

- Has a physical or mental impairment which substantially limits one or more major life activities; or
- Has a record of such an impairment; or
- Is regarded as having such an impairment.

As amended, Section 504 of the Rehabilitation Act of 1973, defines physical or mental impairment as almost any kind of mental or physical condition which would impair the person's functioning in day-to-day living. The specific diseases or conditions that constitute physical and mental impairment shall include but not be limited to the following:

- Visual
- Orthopedic
- Cerebral palsy
- Epilepsy
- Cancer
- Heart disease
- Speech and hearing impairment
- Muscular dystrophy
- Mental retardation
- Emotional Illness
- Drug addiction and alcoholism
- Multiple sclerosis

Note: A physical or mental impairment does not constitute a handicap for purposes of Section 504, unless its severity results in a substantial limitation of one or more major life activities or is treated by the agency as constituting such a limitation.

The State Task Force on 504 has developed the following categories and definitions:

Emotional Disability: Persons with a manifest behavior disorder characterized by situationally inappropriate behavior which deviates substantially from behavior appropriate to the person's age, and significantly interferes with the person's intellectual, social and personal adjustment.

Hearing Disability: Persons with total deafness or inability to hear normal conversation or use a telephone.

Mental Retardation: Persons with subnormal general intellectual functioning which originates during the developmental period and is associated with impairment of either learning and social adjustment or maturation, or both.

NONDISCRIMINATION COMPLIANCE REVIEW, 470-0377 (Cont.)

Orthopedic Disability: Persons with orthopedic impairments, amputations or functional limitations if there is:

- Loss or significant impairment of one or both upper extremities; or
- Loss or significant impairment of one or both major lower extremities; or
- Impairments of the trunk, back of spine when there is a medically diagnosed disability that substantially limits one or more major life activities.

Other Physical Disability: Persons with a medically diagnosed disability which substantially limits one or more major life activities such as stroke, diabetes, arthritis, cerebral palsy epilepsy, spina bifida, heart disease, cancer, rheumatism, muscular dystrophy, and multiple sclerosis.

Speech Impairment: Persons with speech impairments when speech is unintelligible in normal conversation.

Substance Abuse: Persons whose use of a substance is great enough to damage their physical health, or their personal or social functioning. Dependence on medically prescribed drugs is excluded so long as the drug is medically indicated and the intake is proportionate to the medical needs.

Visual Disability: Persons who are legally blind in one or both eyes and whose visual acuity even after correction (eyeglasses or contact lenses) is 20/200 visual acuity or restricted in the visual field to 20 degrees.

FINANCIAL AND STATISTICAL REPORT, 470-0030

The *Financial and Statistical Report*, form 470-0030, is used to report each facility's costs of operation for purposes of rate determination. This standardized financial report provides information on the cost of providing nursing care to Medicaid recipients on a basis that is fair, equitable, and comparable among facilities.

Facilities may request approval from the Bureau of Long-Term Care to use their own computer-generated facsimile instead of the printed form. Instructions for completion are included in Appendix B of this Manual.

The financial report shall be submitted no later than September 30. (State-owned facilities submit the report every six months.) Failure to submit the report within the three-month period shall reduce the family's payment to 75% of the current rate. This reduced rate will be paid for no longer than three months. After that, no further payments will be made by the state. The facility is urged to submit the report early.

FINANCIAL AND STATISTICAL REPORT, 470-0030 (Cont.)

When the reports have been completed and submitted, the material as processed by agents of the Department is used to adjust the individual facility rate. The resultant rate, subject to the ceiling recognized as maximum reasonable cost, is effective with services rendered the first of the month in which the reports were received.

Facilities which are in new buildings or which are entering the nursing facility program for the first time receive a beginning per diem rate at the maximum allowable rate.

ICF/MR RESIDENT CARE AGREEMENT, 470-0374

The *Resident Care Agreement* is completed in triplicate by a worker at the county office of the Department when the resident is approved for Medicaid payment. The facility administrator and the resident sign the forms, and they are returned to the county Department office for signature.

If a resident is unable to sign the forms, a letter "X" or the resident's thumbprint shall be entered to the line reserved for the resident's name. In such cases, the signatures of two witnesses are necessary. A legal guardian may sign for the resident without the need for the signature of a witness. The county office returns one signed copy of the agreement to the facility for its files and furnishes one signed copy to the resident.

ICF/MR PLACEMENT STATEMENT, 470-0375

The *ICF/MR Placement Statement* is a notice to the county regarding its payment of the nonfederal share of the ICF/MR costs for recipients living in community-based facilities. The statement is sent to the county of legal settlement and other interested parties. For those recipients who do not have an established county of settlement, the state shall pay the nonfederal share and the statement is sent to the county of residence.

All copies are sent to the Bureau of Long-Term Care for signature. When completed, the Bureau will keep the Long-Term Care copy and return the other copies to the local worker for distribution as indicated on the form.

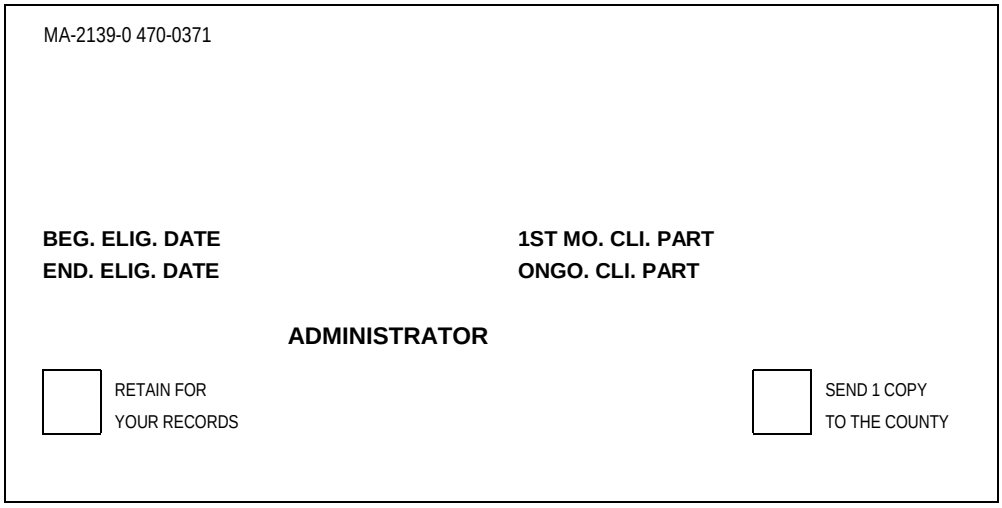
VOLUNTARY CONTRIBUTION AGREEMENT, 470-0373

The contributor shall contact the income maintenance worker at the county office of the Department to initiate the form. The form shall be signed by the contributor, the facility administrator or representative, and a Department representative. The form, completed in three copies, is retained by the contributor, ICF/MR, and the county Department office.

FACILITY CARD, MA 2139-0 (470-0371)

The *Facility Card* is used for determining the authorization for payment for care in an ICF./MR. It is computer-generated in two copies. It is issued by the county office income maintenance worker who determines financial eligibility for Medicaid and submits eligibility and payment information.

The form indicates the first day for which payment may be made, the facility in which the recipient is residing, and the amount of the recipient's available income being applied tot he cost of care (client participation).


MA-2139-0 470-0371

BEG. ELIG. DATE **1ST MO. CLI. PART**
END. ELIG. DATE **ONGO. CLI. PART**

ADMINISTRATOR

RETAIN FOR YOUR RECORDS

SEND 1 COPY TO THE COUNTY

Simultaneously with the sending of this form, a printout containing the person's financial eligibility information is sent to the Bureau of Long-Term Care. When this financial eligibility information is matched with medical approval information furnished by the Iowa Foundation for Medical Care, the resident's file is opened for ICF/MR payment.

Upon receipt of the *Facility Card* for a resident, the ICF/MR shall:

- Check the information on the form for accuracy. If there appears to be an error in the beginning eligibility date, the amount of financial participation, or any other item, contact the Department county office as soon as possible. The information shown on the form is the basis for the ICF/MR payment to the facility.
- Send one copy of the form to the Department county office. Retain the remaining copy as a facility record.

Note: Vendor payments for ICF/MR care are made to participating facilities to supplement the resident's income. The resident retains $30 of income for personal needs. The balance of income is applied to the cost of care. The facility is responsible for collecting these funds from the resident.

CASE ACTIVITY REPORT, 470-0042

The *Case Activity Report* is used to ensure prompt and accurate reporting on resident activity as it occurs at the facility. Complete the form when:

- A current resident applies for Medicaid.
- A Medicaid-eligible resident:
  - Enters the facility
  - Changes level of care
  - Is discharge from the facility
  - Dies

When a Medicaid applicant or recipient enters the facility, complete Sections 1-3 and, if applicable, Section 4. When a Medicaid applicant or recipient dies, complete Sections 1 and 5.

Within two business days of the action, mail the white copy to the Department county office and the yellow copy to the Iowa Foundation for Medical Care. Keep the pink copy.

Section 1. Recipient Data: Section 1 contains resident-specific information. Use the first name, middle initial, and the last name as it appears on the Medical Assistance Eligibility Card. The Date "Entered Facility" is the date the resident entered the facility for the first time, or was readmitted to the facility following a discharge.

Section 2. Facility Data: Section 2 contains information on the facility and he person filling out the form (either the administrator or designee). The "DHS Per Diem" is the facility's computed rate. The "Date Completed" is the date the form is completed and sent to the county DHS office.

Section 3. Level of Care: Section 3 lists the level of care (ICF, Skilled, etc.) as determined by the Iowa Foundation for Medical Care, Medicare, or the managed care contractor. The "Effective Date" is provided by IFMC, Medicare, or the managed care contractor. Your provider number in Section 2 must match the level of care indicated.

Section 4. Medicare Information for Skilled Patients in Skilled Facilities: Section 4 reflects Medicare coverage that may be applicable when a skilled resident is in a skilled nursing facility.

Section 5. Discharge Data: Fill out section 5 when a resident leaves the facility, or dies. The income maintenance worker needs the information to calculate client participation for a partial month.

Provide information under "Last Month in Facility" only if the resident transfers to another facility or living arrangement (but not home).

“Reserve bed days” is the number of reserve bed days, up to the maximum, for which the facility will be reimbursed by the Medicaid program.

“Noncovered days” is the number of days in excess of the reserve bed day limit for which the facility will not be reimbursed by the Medicaid program.

“Total billing days on claim to fiscal agent” is the total of the previous three lines.

For example, the client was in the facility from January 1 through January 5, then was in the hospital January 6-18. The client was then discharged from the hospital to the facility on the 18th. The client stayed in the facility until the 20th, at which point the client transferred to another facility. Form entries would be as follows:

- Date of discharge: January 20
- Days in facility: 8 (January 1-5, 18-20)
- Reserve bed days: 10 (Jan. 6-15)
- Non-covered days: 2
- Total billing days on claim to fiscal agent: 20

MEDICAL ASSISTANCE ELIGIBILITY CARD (FEE FOR SERVICE), 470-1911

The Department issues a Medical Assistance Eligibility Card monthly for each ICF/MR recipient. Eligibility information for up to four recipients is printed on a single perforated sheet. Sheets for all recipients in a facility are batched and mailed to the facility address.

The front of the card contains all the identifying information, including name and individual identification number. Always be careful to use the identification number on the current month's card when submitting claims.

Note the column on the card entitled "other insurance." This refers to health insurance or other types of medical resources held by the resident. If the resident has health insurance, a two-digit code appears opposite the resident's name in this column, to identify the type of resource.

Types of Health Insurance (first digit)

Code	Identification
0	None
A	Hospital
B	Physician
C	Dental
D	Drugs
E	Hospital and physician
F	Hospital, physician, and dental
G	Hospital, physician, dental and drug
H	Hospital and dental
I	Hospital and drug
J	Hospital, physician and drug
K	Physician and drug
L	Physician and dental
M	Hospital, physician, dental, drug and vision
N	Hospital, physician, drug and vision
O	Hospital, physician, and vision
P	Hospital, physician, and other*
q	Hospital, physician, dental and other*
R	Hospital, physician, dental, drug and other*
S	Hospital, dental and other*
T	Hospital, drug and other*
U	Hospital, physician, drug and other*
V	Vision
W	Physician, drug and other*
X	Other*
Y	Physician, dental and other*
Z	Hospital, physician, dental, drug, vision and other*
1	Hospital, physician, drug, vision and other*
2	Hospital, physician, vision and other*

MEDICAL ASSISTANCE ELIGIBILITY CARD (FEE FOR SERVICE), 470-1911 (Cont.)

Types of Health Insurance (first digit) (Cont.)

* "Other" includes but is not limited to:
  Ambulance
  Home health care
  Hospice
  Lab and X-ray
  Medical equipment
  Nursing facility (both nursing and skilled)
  Specific disease (heart, cancer)

Types of Health Insurance (second digit)

Code	Identification
0	None
1	Medicare Part B
2	Medicare Part A and Part B
3	CHAMPVA
4	CHAMPUS
5	Veterans Administration
6	Other medical resources
7	CHAMPUS from an absent parent, not court-ordered
8	CHAMPUS from an absent parent, court-ordered
9	Medicaid Trust
A	Medicare Part A
B	Accident
G	Coverage from absent parent, not court ordered
H	Coverage from absent parent, court ordered
I	Major medical
J	Major medical from an absent parent, not court-ordered
K	Major medical from an absent parent, court ordered
L	Indemnity

When buy-in is completed for Medicare Part B and the code in the second digit of the health coverage does not reflect Part B, the second digit is automatically changed to reflect the new coverage.

IOWA MEDICAID LONG-TERM CARE CLAIM, 470-0039

The fiscal agent issues this form monthly to facilities that do not bill electronically. The following fields are completed for each resident according to fiscal agent and Medicaid eligibility records. Review the form carefully. Mark any changes or correction in red ink, keep one copy and return the other copy to the fiscal agent.

1. **MEDICAID I.D.#.** Enter the resident's I.D. number assigned by the Department. This number consists of seven numbers followed by a letter. The I.D. number can be obtained from form MA-2139, *Facility Card*, or the resident's *Medical Assistance Eligibility Card*.

2. **NAME.** Enter the resident's last name and first name.

3. **L.O.C. (LEVEL OF CARE).** Leave blank if the resident is at ICF or ICF/MR level of care. Enter an "R" if the resident is RCF.

4. **TERMINATION.** Enter the appropriate discharge code:

   A Moved to the hospital
   B Moved to a skilled nursing facility
   C Moved to another nursing facility
   D Moved to an ICF/MR
   E Moved to an RCF
   F Moved home with self care
   G Moved home with rehabilitation service
   H Moved home with home health
   I Moved to other institution
   J Deceased

5. **PATIENT ACCT#.** Enter the resident's account number if your facility assigns one

6. **MEDICARE COVERAGE.** Leave blank.

7. **FACILITY ADMIT DATE.** Enter the date the resident was admitted to the facility if the admission was during the month being claimed.

8. **FACILITY DISC DATE.** If the resident was in the facility the entire month, leave this field blank. If the resident was discharged from the facility during the month, enter the last date service was provided. The entry should show month, day, and year, in a six-digit number.

9. **FIRST D.O.S (Date of Service).** Enter the first date of the month for which payment is being claimed. The entry should show month, day, and year, in a six-digit number.

10. **LAST D.O.S. (Date of Service).** Enter the last date of the month for which payment is being claimed. The entry should show month, day, and year, in a six-digit number.

IOWA MEDICAID LONG-TERM CARE CLAIM, 470-0039 (Cont.)

11. UNLABELED FIELD. Leave this field blank.

12. PER DIEM RATE. Enter the facility's computed daily rate. This rate may not be the same as the facility's Medicaid rate if the facility's computed rate is above the Medicaid reimbursement cap. When the fiscal agent processes the claim, the cap will be applied, and the facility will receive the computed rate or the cap rate, whichever is lower.

13. # **DAYS.** Enter the number of days for the month being claimed from the first day of the month to the last day of the month.

14. AMOUNT. Enter the total amount being claimed as determined by multiplying the per diem (field 12) by the number of days (field 13). When the claim is processed, the facility will be reimbursed based on the facility's computed rate or the cap rate, whichever is lower.

15. LEAVE DAYS/VISIT. Enter the number of covered reserve bed days for a resident who was out of the facility for therapeutic leave or home visit. A covered reserve bed day is one that can be paid by Medicaid. Medicaid will pay to hold the bed while a resident is visiting away from the facility for up to 18 days in any calendar year. See **Periods of Service for Which Payment Will Be Authorized**.

16. LEAVE DAYS/HOSP. Enter the number of covered reserve bed days for a resident who was out of the facility for a hospital stay. A covered reserve bed day is one that can be paid by Medicaid. Medicaid will pay to hold the bed while a resident is in the hospital for up to 10 days in any calendar month.

17. LEAVE DAYS/NON-COV. Enter the number of days that the resident was out of the facility that exceed the reserve bed maximum. These are days that are not reimbursable through the Medicaid program.

18. 3RD PARTY SOURCE. If the resident is covered by other insurance, enter the name of the insurance company.

19. 3rd PARTY AMOUNT. Enter the amount paid by the insurance towards this claim. Do not enter client participation in this field.

20. 3RD PARTY SOURCE. If the resident is covered by other insurance, enter the name of the insurance company.

21. 3RD PARTY AMOUNT. Enter the amount paid by the insurance towards this claim. **Do not** enter **client participation** in this field.

22. NET AMOUNT. Enter the net charge amount which is the amount claimed (field 14) minus third party payments (fields 19 and 21).

Each page of the form must be signed by the facility's authorized representative, and dated. Resubmitted claims must use the original signature date.

REMITTANCE ADVICE

You will receive a comprehensive Remittance Advice with each Medicaid payment. The Remittance Advice is also available on magnetic computer tape for automated account receivable posting.

The Remittance Advice is separated into categories indicating the status of those claims listed below. The categories are:

- PAID, indicating all processed claims, credits, and adjustments for which there is full or partial reimbursement.
- DENIED, representing all processed claims for which no reimbursement is made.
- SUSPENDED, reflecting claims which are currently in process pending resolution of one or more issues (recipient eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which of these options you have specified:

- Print suspended claims only once.
- Print all suspended claims until paid or denied.
- Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims, with the exception that the transaction control number contains a “1” in the twelfth position and reimbursement appears as a negative amount.

An adjustment to a previously paid claim produces two transactions on the Remittance Advice. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a “2” in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit - the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

When it is necessary to contact the fiscal agent with questions, keep the Remittance Advice handy. Refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

A detailed field-by field description of each information line follows.

1. Billing provider’s name as specified on the Medicaid Provider Enrollment Application.
2. Remittance advice number.
3. Date claim paid.

REMITTANCE ADVICE (Cont.)

4. Billing provider's Medicaid (Title XIX) number.

5. Remittance Advice page number.

6. Type of claim used to bill Medicaid.

7. Status of following claims:

   - Paid - claims for which reimbursement is being made.
   - Denied - claims for which no reimbursement is being made.
   - Suspended - claims in process. These claims have not yet been paid or denied.

8. Recipient's last and first name.

9. Recipient's Medicaid (Title XIX) number.

10. Transaction control number assigned to each claim by the fiscal agent. Please use this number when making claim inquires.

11. Total charges submitted by provider.

12. Total amount applied to this claim from other resources, i.e. other insurance or spenddown.

13. Total amount of Medicaid reimbursement as allowed for this claim.

14. Total amount of recipient copayment deducted from this claim.

15. Medical record number as assigned by provider; 10 characters are printable.

16. Explanation of benefits code for informational purposes or to explain why a claim denied. Refer to the end of remittance advice for explanation of this code.

17. Line item number.

18. The first date of service for the billed procedure.

19. The procedure code for the rendered service.

20. The number of units of rendered service.

21 Charge submitted by provider for line item.

22. Amount applied to this line item from other resources, i.e. other insurance, spenddown.

23. Amount of Medicaid reimbursement as allowed for this line item.

REMITTANCE ADVICE (Cont.)

24. Amount of recipient copayment deducted for this line item.

25. Treating provider's Medicaid (Title XIX) number.

26. Allowed charge source code:

B Billed charge
F Fee schedule
M Manually priced
N Provider charge rate
P Group therapy
Q EPSDT total screen over 17 years
R EPSDT total under 18 years
S EPSDT partial over 17 years
T EPSDT partial over 18 years
U Gynecology fee
V Obstetrics fee
W Child fee

27. Remittance totals (found at the end of the remittance advice):

- ♦ Number of paid original claims, the amount billed by the provider and the amount allowed and reimbursed by Medicaid.
- ♦ Number of paid adjusted claims, amount billed by provider and amount allowed and reimbursed by Medicaid.
- ♦ Number of denied original claims and amount billed by provider.
- ♦ Number of denied adjusted claims and amount billed by provider,
- ♦ Number of denied claims (in process) and amount billed by provider.
- ♦ Amount of check.

28. Description of individual of benefits codes. The EOB code leads, followed by important information and advice.

CREDIT/ADJUSTMENT REQUEST FORM, 470-0040

Form 470-0040, *Credit/Adjustment Request* is used to notify the fiscal agent of credits and adjustments that need to be made on a claim that has already been paid. It is not used with a claim has been denied. A denied claim must be resubmitted.

Send *Credit/Adjustment Request* forms directly to ACS for processing, you can send them at any time of the month. You must send a copy of the *Remittance Advice* or a copy of the corrected claim with the form.

Section A:

Claim Adjustment. Check this box when the fiscal agent has paid a claim but there is an adjustment that must be made. Examples of such situations are:

- You billed a day as a bed hold day, then later determined that the client had actually returned to the facility on that day.
- A resident was scheduled to be discharged from the facility on a particular day but stayed an additional day, and this was not noted until after the billing month.

Claim Credit. Check this box when an entire paid claim should be credited back to the Medicaid program. An example is when you received payment for a client who had already been discharged.

Cancellation of Entire Remittance Advice. This box is checked when every paid claim on the *Remittance Advice* is incorrect and must be canceled.

Section B:

1. **17-Digit TCN**. For each claim, a "transaction control number" (TCN) is listed on the Remittance Advice. Enter that number in this field. See the *Remittance Advice* instructions on where to find the TCN number on the *Remittance Advice*.
2. **Pay-To-Provider Number**. Enter your seven-digit Medicaid provider number in this field.
3. **Provider Name/Address.** Self-explanatory.
4. **8-Character Iowa Medicaid Recipient ID**. Enter the resident's Medicaid state identification number in this field. The number will be 7 digits followed by a letter You can obtain it from the *Remittance Advice*, the resident's *Medicaid Eligibility Card*, or the *Facility Card*.
5. **Reason for Adjustment or Credit Request.** Self-explanatory.

CREDIT/ADJUSTMENT REQUEST FORM, 470-0040 (Cont.)

Section C:

Provider/Representative Signature and **Date.** The form must be signed and dated by a facility representative.

The bottom part of the form is for internal use by ACS.

ADJUSTMENT TO FACILITY PAYMENT, 470-0041

The county office income maintenance worker uses the *Adjustment to Facility Payment* to correct errors in client participation that have caused overpayments or underpayments to a facility. (If the error is discovered before the facility billing cycle, it can be corrected without using this form.)

Most of the items on the form are self-explanatory.

The beginning adjustment date is the start of the month in which the incorrect client participation was used, and the ending adjustment date is the end of the month in which the adjustment is required.

When the amount of the client participation is the same for more than one month, all months can be combined on one line. When the amount differs, different lines must be used.

The level of care code for ICF/MR is M, as it is on the *Long-Term Care Claim*.

A copy of the form is mailed to the facility to verify that the correction has been submitted. Monitor these reports and the resulting billings. Report any discrepancies to the resident’s income maintenance worker.

APPENDIX B:
COMM. 48, INSTRUCTIONS FOR FORM 470-0030, FINANCIAL AND STATISTICAL REPORT

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

July 30, 2003

GENERAL LETTER NO. 8-I-AP-10

ISSUED BY: Bureau of Long-Term Care

SUBJECT: Employees' Manual, Title 8, Chapter I, ***MEDICAL INSTITUTIONS APPENDIX***, Comm. 46, *Medicaid Provider Manual for Intermediate Care Facilities for the Mentally Retarded*, Table of Contents (pages ii and iii), revised; pages 2, 9, 10, 33 through 38, and 43 through 52, revised; pages 53 through 55, new; Appendix A, pages A1 through A10, A14, A15, A19, A20, and A21, revised; Appendix B, Title page, revised, and page 28, revised; and the following forms:

HCFA-671	*Long Term Care Facility Application for Medicare and Medicaid*, revised
470-0372	*ICF/MR Provider Agreement*, revised
470-0377	*Nondiscrimination Compliance Review*, revised
470-0030	*Financial and Statistical Report*, revised
470-0375	*ICF/MR Placement Statement*, revised
470-0042	*Case Activity Report*, revised
470-0039	*Iowa Medicaid Long-Term Care Claim*, revised
470-0040	*Credit/Adjustment Request*, revised
470-0041	*Adjustment to Facility Payment*, revised

Summary

The ICF/MR provider manual is revised to:

- Provide information on the ICF/MR assessment fee imposed by 2002 Iowa Acts, Second Extraordinary Session, Chapter 1001, sections 36 and 46. Schedule C of the *Financial and Statistical Report* is revised to include a line for reporting the fee, and the form instructions are revised accordingly.
- Update other form samples and instructions. The numbering system on Department forms has changed. References to the Division of Medical Services have been changed to the Bureau of Long-Term Care. References to the Medicaid fiscal agent have changed from "Consultec" to "ACS." The sources for some forms have changed.

Effective Date

February 1, 2003

Material Superseded

Remove the following pages from Employees' Manual, Employees' Manual, Title 8, Chapter I, *Medicaid Provider Manual for Intermediate Care Facilities for the Mentally Retarded*, and destroy them:

Page	Date
Contents (pp. ii and iii)	November 1997
2, 9, 10	March 1993
33	July 1994
34-38	March 1993
42a-42c, 43, 44	November 1997
45-52	March 1993
A1-A4 *	November 1997
HCFA-671	1/90
MA-2147-0 (470-0372) (12 pp.)	1/81
470-0377 (4 pp.)	7/91
A5, A6	March 1993
AA-4036-0 (470-0030) (15 pp.)	8/97
A7, A8	March 1993
MA-2152-0 (470-0375)	2/91
A9	March 1993
A10	July 1997
AA-4166-0 (470-0042)	6/97
A14	November 1997
AA-4163-0 (470-0039)	Undated
A15	November 1997
AA-4164-0 (470-0040)	Undated
A19, A20	November 1997
AA-4165 (470-0041)	7/97
A21	July 1997
Appendix B, Title page	March 1993

* Move form 470-0254 to follow page A2 instead of page A4. Move form HCFA-1513 to follow revised form HCFA-671 and precede page A3

Additional Information

Refer questions about this general letter to the Bureau of Long-Term Care.

As of this revision, this manual will be available on the Internet through the Department's web site at http://www.dhs.state.ia.us/policyanalysis/. In the future, only the transmittal letter will be mailed to providers. You may view and print the revised pages from the web site.